Oregon

HRSA State Planning Grant

Final Report to the Secretary

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Executive Summary

OREGON HAS PROVIDED a laboratory for health care strategies over the last two decades. This report provides perspectives on current strategies that Oregon is considering to move closer to universal access. Two strategies are highlighted, Oregon Health Plan (OHP2), which promotes an expansion of public and private coverage by reallocating current resources, and CHIP Too, promoting access to primary care services in ways that complement the OHP2 coverage strategy.

These strategies arise at a time of transition for the state. The end of the Kitzhaber era approaches. Term limits promise a future in which state leadership of health care will be in constant transition. The Oregon economy, so robust in the 1990s, is in decline. After two decades of market competition, Oregon's health care delivery system remains engaged in the Oregon Health Plan but in very different ways than originally envisioned. The turbulence of the last decade has taken its toll and providers of care remain concerned that any new turbulence could destabilize them further.

Consumers and their advocates appreciate the gains that have been made but encounter a health care system that is increasingly difficult to access and, once again, expensive beyond the means of many. The wonders of medical advances have never been more apparent and more difficult to access for some. Taxpayers continue to identify strongly with the Oregon Health Plan but are as divided as ever about the way to finance the changes that are necessary. Comprehensive reform remains elusive but interest remains in pursuing incremental change that builds on previous OHP approaches. The next months will reveal whether interest translates into consensus as the state pursues waiver efforts related to both of the strategies outlined in this report.

Sections 1 and 2 of the report summarize information about the uninsured in Oregon, low-income uninsured (from 100–200% of the FPL), the employer based health insurance system and the outcomes of approaches Oregon has taken over the last decade. There is unique information provided about benefits, subsidy programs for low income populations and the substantial enrollment dynamics that occur when income becomes a major criteria for eligibility. More information about all of these issues is on the way and will be included in a second report in Spring 2002.

A more qualitative sense of the Oregon health marketplace is described in Section 3 of the report. Issues around benefits, subsidy approaches and access approaches dominate the discussion. Allocation and reallocation of resources is a constant theme and reflects the importance of this issue within the state. Both strategies described in the report, OHP2 and CHIP Too, are currently in the midst of explicit public discussions centered around tradeoffs and reallocation.

OHP2, the insurance coverage strategy, and CHIP Too, the access model, are described in Section 4. OHP2 proposes to create a second Medicaid benefit plan for adults based on income. This benefit plan would provide basic coverage and more similar to private insurance coverage. Savings from this new benefit plan will be reallocated to finance expansion for adults and

children at higher incomes than those currently covered. Oregon's success with a state-only funded subsidy program, the Family Health Insurance Assistance Program (FHIAP), is proposed as a vehicle for the purchase of private insurance for the expansion population, thereby receiving match from the federal government. Tradeoffs and reallocation decisions are critical to the success of this approach. CHIP Too, a much smaller but equally important strategy that acknowledges the current limits of coverage strategies, proposes to use CHIP funds to directly reimburse accountable and organized safety net clinics providing primary care to eligible but not yet enrolled children while enrollment in coverage options are pursued. Not surprisingly, trade offs and reallocation decisions are crucial to this strategy also. Many of the decision details, to be tested in a variety of decision making environments, will be updated in Oregon's Spring 2002 report.

Section 5 provides perspectives on Oregon's consensus building strategies. While multiple strategies have been pursued, ideas that promise a universal solution impose the most rigorous requirements on public stakeholder involvement. This is not an easy task.

Oregon's recommendations to other States and to the Federal Government are outlined in Sections 6 and 7. Many are based on repeated experiences as well as solid data. Others are more qualitative consensus suggestions. Some are likely very "Oregon" in nature, but working with other states has made Oregon realize that states are more similar than different. Very modest changes in the political and economic culture of a state can provide opportunities or inhibit them. States can keep universal coverage and access on the front burner and make substantial progress in almost any set of political and economic circumstances. It is that important and a lot of people share that belief.

Oregon appreciates the chance to work with other states and with HRSA on this project. Oregon's Grant Team has worked on this much like the thirteen original states must have worked on the issues most important to them—interdependent but independent. HRSA has been a facilitator throughout—encouraging, persistent, reassuring, open. Some state or states are going to figure this out. Oregon hopes to contribute to that effort.

Section 1

Uninsured Individuals and Families

1.1 What is the overall level of uninsurance in your State?

Since 1990 Oregon has relied on a state-sponsored biennial survey called the Oregon Population Survey (OPS). The survey is jointly administered by the state Office of Economic Analysis and the Oregon Progress Board with assistance from the Oregon Population Survey Task Force. The OPS measures socioeconomic characteristics of Oregonians including health insurance status.*

Oregon's HRSA Team chose to use OPS as the source of data instead of the Census Bureau's Current Population Survey (CPS) for the following reasons:

> ***The OPS provides point-in-time estimates.*** OPS asks respondents if they are insured or uninsured at the time of the survey; CPS asks respondents whether they had health insurance coverage at any time during the previous calendar year. Both point-in-time estimates (OPS) and over-time estimates (CPS) are useful measures, but the CPS approach relies on a respondent's ability to recall his/her insurance status for the prior 14 to 15 months.
>
> ***The OPS asks direct, easy to answer questions about health insurance status.*** In the past, OPS and CPS have taken different approaches to learning about the respondent's health insurance status. The OPS asks, "*Are you currently insured?"* In contrast, CPS has relied on a residual approach, asking whether respondents are covered by specific types of health insurance. In March 2000, CPS added additional questions to directly ask respondents if they were uninsured (verification questions). After analyzing the impact of these changes, which resulted in an overall 7.7% decline in the number of uninsured, the Census Bureau decided to include the new questions in future surveys.[1] Based on the new methodology, the Census Bureau recently revised its 1999 estimate of Oregon's uninsured rate from 14.6% to 13.9%. No detailed information is available yet.
>
> ***The OPS uses a larger sample than CPS.*** The OPS samples about 5,600 households, compared to about 1,900 for CPS. The OPS also collects insurance information on each member of the surveyed household generating a total database of more than 10,000 individuals. This larger sample greatly reduces the margin of error. Because of sample size problems, the State Health Access Data Assistance Center (SHADAC) recommends using state-specific CPS estimates only as three-year rolling averages.[2] While such a strategy would provide a measure of stability, Oregon would lose its ability to monitor year-by-year change.

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* For more general information about the Oregon Population Survey, please see *www.oea.das.state.or.us/ops2000/ops.htm.*

The OPS over-samples for minorities and for regions of the State. In order to provide meaningful data about minority populations in Oregon, the OPS is designed to over-sample certain populations. The OPS also divides Oregon into eight meaningful regions and over-samples these areas as well. This allows us to make much more accurate subgroup estimates.*

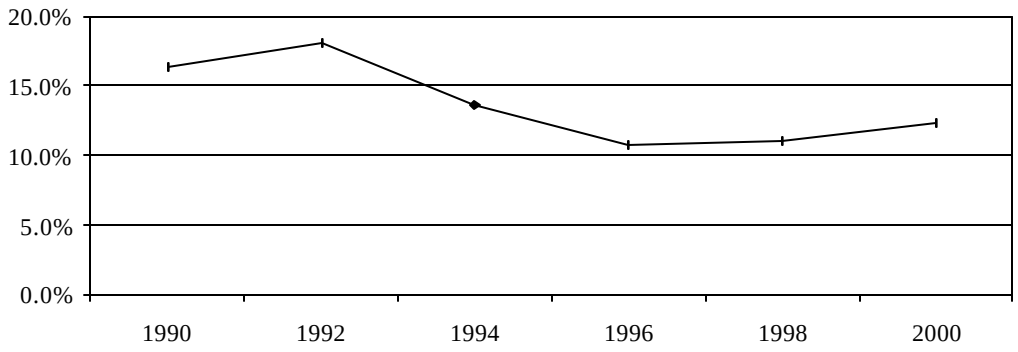
Based on responses to the OPS question: *"Are you currently covered by some type of health insurance?"* Oregon's overall level of uninsurance was 12.3% in 2000. The trend since 1990 is shown in Tables 1.1 and Figure 1.A:

Table 1.1: Uninsurance in Oregon 1990–2000

Year	Uninsured Rate	# Estimated Uninsured
1990	16.4%	467,740
1992	18.1%	539,956
1994	13.6%	424,796
1996	10.7%	348,597
1998	11.0%	367,904
2000	12.3%	423,149

Source: *Office of Health Plan Policy and Research*

Figure 1.A: Uninsured Rates: 1990–2000



Source: *Office of Health Plan Policy and Research*

* For a more detailed discussion of the differences between OPS and CPS, please see *Varying Rates of Uninsurance Among Oregonians: A Critical Comparison of Two Household Surveys* (*www.ohppr.state.or.us/docs/pdf/uninsured.pdf*).

Oregon's rate of uninsurance decreased dramatically between 1992 and 1996—the result of strong economic growth and State initiatives such as the Oregon Health Plan and small group insurance reforms. However, since 1996 the rate of uninsurance has been slowly increasing.

1.2 What are the characteristics of the uninsured?

Income:

Oregon's publicly funded programs are linked to the Federal Poverty Level (FPL), therefore uninsured rates are shown by FPL instead of income. As shown in Table 1.2, of approximately 423,000 uninsured Oregonians, about two-thirds (67.2%) have household incomes at or below 200% of the FPL.

Table 1.2: 2000 Uninsured Rates by Poverty Status

Income Level	Uninsured Rate	# Estimated Uninsured	% All Uninsured
At or below 100% of FPL	26.4%	115,006	27.2%
101–200%	18.9%	169,125	40.0%
201–300%	9.4%	64,074	15.1%
+300%	5.3%	74,944	17.7%
All income levels	12.3%	423,149	100.0%

Source: *OPS 2000*

Uninsurance and Age:

As shown in Table 1.3, of the uninsured, more than 77.7% are between the ages of 19 and 64. Almost 20% of the uninsured are aged 18 and younger, leaving more than 81,000 children uninsured:

Table 1.3: 2000 Uninsured Rates by Age

Age Range	Uninsured Rate	# Estimated Uninsured	% of All Uninsured
0–18	9.0%	81,454	19.2%
19–64	15.7%	328,699	77.7%
65+	3.0%	12,996	3.1%
Total (all ages)	12.3%	423,149	100.0%

Source: *OPS 2000*

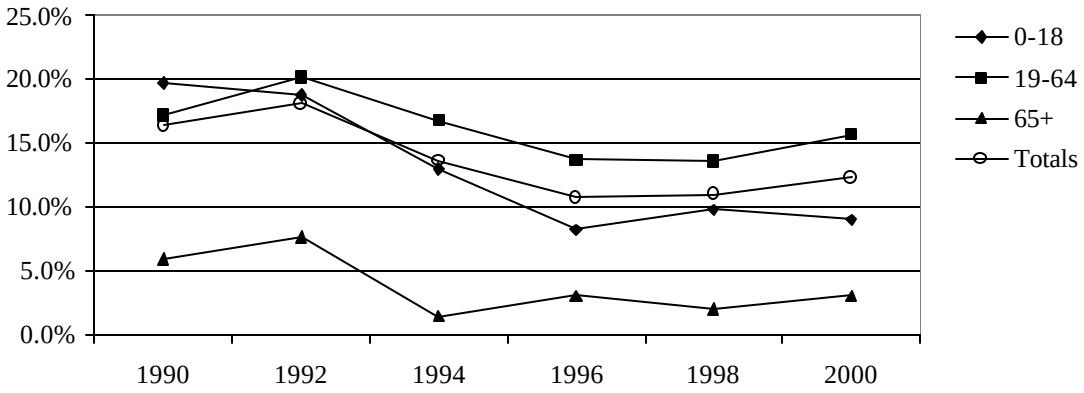
Over the last decade, the uninsurance rates for children (0–18) and those aged 65 and older have decreased faster than the uninsurance rates for adults aged 19–64 (see Table 1.4 and Figure 1.B). In fact, uninsurance rates for adults aged 19–64 increased in 2000.

Table 1.4: Uninsured Rates by Age Range: 1990–2000

Year	0–18	19–64	65+	Totals (%)
1990	19.7%	17.2%	5.9%	16.4%
1992	18.8%	20.2%	7.6%	18.1%
1994	13.0%	16.8%	1.4%	13.6%
1996	8.2%	13.7%	3.0%	10.7%
1998	9.8%	13.6%	2.0%	11.0%
2000	9.0%	15.7%	3.0%	12.3%

Source: *Office of Health Plan Policy and Research*

Figure 1.B: Trends in Uninsured Rates By Age: 1990–2000



Source: *Office of Health Plan Policy and Research*

As seen in Table 1.5, income level has a powerful impact on insurance status. For example, children living below the FPL have an uninsurance rate of 18%; those living above 300% of the FPL have a rate of slightly less than 4%. In fact, 74% of Oregon's uninsured children live in households with incomes below 200% of the FPL.[*]

[*] Please see Appendix 1 for more information about the *number* of insured below the FPL.

Table 1.5: Uninsured Rates by Age and Income level

Age	0–100% FPL	101–200%	201–300%	+300%	Totals (%)
0–18	18.0%	13.4%	4.9%	3.9%	9.0%
19–64	37.0%	27.6%	13.2%	6.2%	15.7%
65 +	9.2%	2.0%	1.9%	1.0%	3.0%
Totals	26.4%	18.9%	9.4%	5.3%	12.3%

Source: *OPS 2000*

Gender:

As shown in Tables 1.6, men are more likely to be uninsured than women; Table 1.7 shows that men with very low incomes are especially likely to be uninsured.

Table 1.6: Uninsured Rates by Gender

	Uninsured Rate	# Uninsured	% All Uninsured
Female	10.3%	178,383	42.2%
Male	14.4%	244,766	57.8%
Totals	12.3%	423,149	100.0%

Source: *OPS 2000*

Table 1.7: Uninsured Rates by Gender and Income

	Female		***Male***	
	Uninsured Rate	**# Uninsured**	**Uninsured Rate**	**# Uninsured**
0–100% FPL	21.4%	50,367	32.3%	64,639
101–200%	15.9%	72,033	21.9%	97,092
201–300%	7.1%	24,351	11.8%	39,723
300+%	4.5%	31,632	6.0%	43,312
Totals	10.3%	178,383	14.4%	244,766

Source: *OPS 2000*

Family Composition:

As shown in Table 1.8, single parent households have much higher rates of uninsurance than other types of households.

Table 1.8: Uninsured Rates by Family Type

	Uninsured Rate	Estimated # Uninsured	% of All Uninsured
Single	15.1%	117,227	27.7%
Single Parents	20.1%	70,358	16.6%
Couples	12.0%	66,735	15.8%
Families	9.6%	168,829	39.9%
Totals	12.3%	423,149	100.0%

Source: *OPS 2000*

Table 1.9 shows that almost 44% of the uninsured are adults living in households with no children present:

Table 1.9: Uninsured Rates by Children in Household

	Uninsured Rate	Estimated # Uninsured	% of All Uninsured
Children in Household	11.4%	239,187	56.5%
No Children in Household	13.8%	183,962	43.5%
Totals	12.3%	423,149	100.0%

Source: *OPS 2000*

Table 1.10 shows the interactions of poverty status and family composition:

Table 1.10: Uninsured Rates by Children in Household and FPL

	0–100% of FPL		***Greater than 100% of FPL***	
	Uninsured Rate	**# Uninsured**	**Uninsured Rate**	**# Uninsured**
Children in Household	27.4%	70,289	9.1%	168,897
No Children in Household	25.0%	44,717	12.1%	139,245
Totals	26.4%	115,006	10.3%	308,143

Source: *OPS 2000*

Health Status:

The OPS does not include health status questions. However, Oregon's HRSA Team completed two quantitative research projects that measured health status as a function of insurance status:*

- A survey of the Family Health Insurance Assistance Program (FHIAP), subsequently referred to as the *FHIAP Study*
- A statewide household survey of Oregon's general population, subsequently referred to as the *Household Survey*

The *Household Survey* contained the question: "*In general, would you say your health is excellent, very good, good, fair, poor?"* Note that the overall results shown in Table 1.11 are very similar to the much larger Behavioral Risk Factor Surveillance System (BRFSS) survey done annually in Oregon.[3]

The *Household Survey* suggests that the relationship between health status and insurance status is a complicated one. On the one hand, more insured individuals reported their health status as *poor* compared to the uninsured (4.3% versus 1.3%). Perhaps this supports the idea that most families make rational choices about their health insurance needs—many of the uninsured are young and healthy (and at relatively low risk) while many of the insured are in poor health (which is why they want health insurance). However, it is also true that more insured reported their health status as *excellent* compared to the uninsured (25.2% versus 19.2%):

Table 1.11: Health Status by Insurance Status

Health Status	Insured Group	Uninsured Group	All Groups	2000 BRFSS
Excellent	25.2%	19.2%	24.5%	19.7%
Very Good	29.0%	37.2%	29.9%	33.0%
Good	32.2%	19.2%	30.7%	30.2%
Fair	9.4%	23.1%	10.9%	13.2%
Poor	4.3%	1.3%	4.0%	3.9%

Sources: *Household Survey; Oregon Behavioral Risk Factor Surveillance System*

The *Household Survey* also suggests a close relationship between health status and income. Individuals with incomes below 200% of the FPL were much more likely to report they were in *fair* or *poor* health than those who were above 200% of the FPL (see Table 1.12).

* Please see *www.ohppr.org/hrsa/index_hrsa.htm* for details on methods and on findings from these two surveys.

Table 1.12: Self-Reported Health Status by FPL

Health Status	0–200% of FPL	Above 200% of FPL
Excellent	11.4%	28.5%
Very Good	27.6%	33.4%
Good	37.4%	28.5%
Fair	13.8%	7.6%
Poor	9.8%	2.1%

Source: *Household Survey*

The *FHIAP Study* posed the identical question as was used in the *Household Survey*.[*] The *FHIAP Study* was designed to learn about two target groups, those enrolled in FHIAP and those on FHIAP's reservation (wait) list. Demographically the two groups are very similar.[†] Both groups value health insurance and both are willing to pay some portion of the cost. However the groups differ in one important aspect—all (100%) of those enrolled in FHIAP are insured and have access to health care while only 35% of the reservation list report being insured, primarily through the Oregon Health Plan. As shown in Table 1.13, it is clear that FHIAP enrollees report their health status as better than those on the wait list who are currently uninsured.

Table 1.13: Self-Reported Health Status by FHIAP Status

Health Status	FHIAP Enrollees	FHIAP Wait List*
Excellent	13%	5%
Very Good	30%	17%
Good	34%	41%
Fair	18%	28%
Poor	4%	8%

Note: *tabulations include only those who are uninsured*
Source: *FHIAP Study*

FHIAP respondents were asked to compare their current health status with their health status a year ago. Enrollees were more likely to note improvements. Twenty-six percent (26%) said they were better; 15% reported they were worse. People on the wait list who were uninsured were more likely to report a worsening of their health status. Fifteen percent (15%) said they were better; 33% reported they were worse.

[*] The question was: "*In general, would you say your health is excellent, very good, good, fair, poor?*"
[†] Please see *www.ohppr.org/hrsa/index_hrsa.htm*.

Employment Status:

Overall, about 74% of uninsured working-age adults are employed (see Table 1.14). But only about one-third of those who work (23.5% of all uninsured or approximately 77,000 people) have access to ESI coverage. In addition, not all people who work at firms that offer coverage would be eligible. Based on statewide statistics about 80% of those offered coverage are eligible. Therefore, of the 77,000 who have access to ESI coverage, up to 62,000 are eligible (though low-income workers probably have lower eligibility rates than average). Of those eligible, an estimated 35,000 workers have family incomes below 200% of the FPL. Assuming an average family size of 2.5,[4] these workers could represent as many as 87,500 uninsured people who live below 200% of the FPL and are eligible for ESI.

Table 1.14: All Uninsured Aged 18–64

	Working		***Not Working***
FPL Status	**% ESI Available**	**% No ESI Available**	**% Not Working**
0–100% FPL	18.3%	52.6%	29.2%
101–200%	21.7%	45.1%	33.2%
201–300%	28.6%	54.0%	17.4%
+300%	26.6%	50.4%	19.0%
Totals	23.5%	50.5%	26.0%

Source: *Pooled 1996/1998/2000 OPS data. ESI = Employer Sponsored Insurance*

Availability of private coverage (including offered but not accepted):

Since 1996–1997 the U.S. Bureau of the Census has fielded an annual survey of employers called the Medical Expenditure Panel Survey Insurance Component (MEPS-IC).[5] The MEPS-IC contains data pertaining to employer-based insurance coverage and addresses issues related to the amount, types and costs of health insurance available through the workplace. The MEPS-IC represents a unique source of information about employer-sponsored insurance.

The MEPS-IC is a national survey that includes an annual sample of 550–600 Oregon-based employers, both private and public sector. Four years of data are available (1996–1999). Tables 1.15 through 1.20 are based on 1998 Oregon-only estimates;[*] findings are limited to private employers. Since MEPS-IC is based on a random sample of employers the data are subject to sampling error.

According to MEPS-IC data, Oregon has almost 90,000 private firms. Most of these are small firms—3 of every 4 companies have fewer than 25 employees. However, these firms represent a small proportion of the total work force (see Table 1.15).

[*] 1999 MEPS data became available too late to be included in this report.

Table 1.15: Private-Sector Employers and Employees by Firm Size

Firm Size	# Firms	% Firms	# Employees	% of All Employees
1–9	56,940	63.8%	226,077	16.7%
10–24	11,633	13.0%	147,788	10.9%
25–99	6,860	7.7%	213,225	15.8%
100–999	5,633	6.3%	263,103	19.5%
1000+	8,201	9.2%	499,630	37.0%
Totals	89,267	100.0%	1,349,823	100.0%

Source: *1998 MEPS, Oregon only*

Based on MEPS-IC data about 83% of Oregon's private-sector workers are employed in companies that offer health insurance (see Table 1.16). Firm size is a key predictor of offer rates; as firm size decreases, offer rates decrease. In fact of the 227,645 workers who are not offered ESI, 97% work in firms with fewer than 100 employees:

Table 1.16: Private Employer Offer Rates by Firm Size

Firm Size	% Firms that Offer	% Employees in Firms that Offer	# Employees in Firms that Offer	# Employees in Firms that Do Not Offer
1–9	31.5%	40.8%	92,239	133,838
10–24	71.9%	74.1%	109,511	38,277
25–99	79.4%	77.3%	164,823	48,402
100–999	91.5%	99.0%	260,472	2,631
1000+	98.7%	99.1%	495,133	4,497
Totals	50.4%	83.1%	1,122,178	227,645

Source: *1998 MEPS, Oregon only*

While firm size is a good predictor of whether an employer will *offer* health coverage to workers, it is not as good a predictor of *take-up* rates.* As shown in Table 1.17, the MEPS-IC data suggest that eligible employees in small firms are almost as likely to accept coverage as employees of large firms.

* Defined as the percent of eligible workers who accept offered coverage.

Table 1.17: Private Employer Eligibility and Take-up Rates by Firm Size

Firm Size	% Employees Eligible for and Offered Health Insurance	# Employees Eligible	% Enrolled	# Employees Enrolled	Take Up Rates (Enrolled/ Eligible)
1–9	84.1%	77,573	68.7%	63,368	81.7%
10–24	78.9%	86,404	64.0%	70,087	81.1%
25–99	70.3%	115,871	56.9%	93,784	80.9%
100–999	77.1%	200,824	67.9%	176,860	88.1%
1000+	85.4%	422,844	78.6%	389,175	92.0%
Totals	80.5%	903,516	70.7%	793,275	87.9%

Source: *1998 MEPS, Oregon only*

Even though Table 1.17 shows that take-up rates are relatively high (87.9% overall) about 110,000 workers appear to decline coverage for which they are eligible.

Availability of public coverage:[*]

In addition to official enrollment reports, the OPS provides some insights into who receives public coverage (See Table 1.18).

Table 1.18: Primary Source of Health Insurance (those 18–64)

	Employer	Public	Individual	Uninsured
0–100% FPL	30.9%	33.6%	8.3%	27.8%
101–200%	50.9%	13.0%	8.9%	27.3%
201–300%	75.4%	3.2%	8.0%	13.3%
+300%	84.9%	1.5%	8.1%	5.5%
Totals	71.8%	7.0%	8.2%	13.0%

Note: *Since these numbers are pooled 1996/1998/2000 OPS data they will not exactly match prior tables.*

For working aged adults, ESI is the most prevalent source of health insurance except for those at or below the federal poverty level.

Race/Ethnicity:

As shown in Table 1.19, the OPS data suggests that uninsurance rates are similar across major race categories.

[*] Please see *www.sdsd.hr.state.or.us/resources/programs/index.htm* for information about the enrollment criteria for Oregon's public coverage programs and current enrollment levels.

Table 1.19: Uninsured Rates by Race

Ethnicity	Uninsured Rate	# Uninsured
African-American	11.5%	8,712
Asian	9.7%	11,230
Native American	10.9%	11,803
White	11.8%	347,781
Other	21.6%	29,917
Missing	23.3%	13,706
Totals	12.3%	423,149

Source: *OPS 2000*

In addition to asking respondents to identify their race, the OPS asks respondents if they are Spanish, Hispanic or Latino. Table 1.20 shows that those who responded "yes" have an uninsured rate twice that of the state average.

Table 1.20: Uninsured Rates by Self-Report Spanish, Hispanic or Latino

	Uninsured Rate	# Uninsured
Hispanic	24.6%	90,763
Non-Hispanic	10.8%	331,653
Missing	29.7%	733
Totals	12.3%	423,149

Source: *OPS 2000*

Immigration Status:

The OPS does not provide information about immigration status.

Geographic location:

Uninsurance rates vary by area of the state.[*] As shown in Table 1.21, The Gorge Region (along the Columbia River) and the Southwest Region have the highest rates of uninsurance.

[*] Please see Appendix I for information about each region.

Table 1.21: Uninsured Rates by Area of the State

Region	Uninsured Rate	Estimated # Uninsured	% of All Uninsured
Central Oregon	11.3%	17,432	4.1%
Eastern Oregon	15.0%	29,632	7.0%
Gorge	16.3%	8,267	1.9%
Metro	11.5%	161,717	38.2%
Mid-Valley	9.3%	41,643	9.8%
North Coast	10.5%	10,857	2.6%
South Valley	12.8%	69,630	16.5%
Southern/Central	14.3%	10,439	2.5%
Southwest	16.0%	73,531	17.4%
Totals	12.3%	423,149	100.0%

Source: *OPS 2000*

Duration of uninsurance:

In order to learn more about the dynamics of temporary versus long-term uninsurance, OPS researchers asked two additional health insurance questions:

- *"At any time in the last 12 months, were you without health insurance?"*
- *"How many months were you uninsured?"*

By the first measure 18.8% of Oregonians lacked coverage for some of the year prior to the 2000 survey. In other words, more than 646,000 Oregonians experienced at least short-term gaps in coverage during a 12-month period from Spring 1999 to Spring 2000.

As shown in Table 1.22 low-income Oregonians were much more likely to experience periods of uninsurance.

Table 1.22: Responses to: *"At any time in the last 12 months, were you without health insurance?"*

FPL Status	Uninsured Rate	Estimated # Uninsured
0–100% FPL	39.1%	170,391
101–200%	27.6%	247,925
201–300%	14.8%	100,540
300%	9.5%	127,938
Totals	18.8%	646,794

Source: *OPS 2000*

As a follow-up question, those without health insurance in the prior twelve months were asked how many months they were without coverage. Overall, 47.3% of those without health insurance said they were uninsured for the entire 12 months, (see Table 1.23). Curiously, while those with low-incomes have higher rates of uninsurance, they were no more likely to be continuously uninsured (uninsured during all 12 months) than those with higher income:

Table 1.23: Responses to: "*Number of Months Uninsured in last 12 months?*"

	6 Months or Less	7–11 Months	12 Months	# Uninsured for 12 Months
0–100% FPL	34.2%	15.9%	49.8%	84,925
101–200%	42.4%	8.8%	48.8%	120,950
201–300%	42.2%	10.2%	47.6%	47,848
300%	47.8%	11.2%	41.0%	52,367
Totals	41.3%	11.4%	47.3%	305,904

Source: *OPS 2000*

Looking at age, Tables 1.24 and 1.25 show that Oregonians aged 65 and older appear to be relatively protected from short term periods of uninsurance. However, one in seven children and one in five working aged adults are likely to have a period of uninsurance in the course of a year.

Table 1.24: Responses to: "*Uninsured anytime in last 12 months?*"

Age	% Uninsured	# Uninsured
0–18	15.8%	142,772
19–64	23.0%	482,600
65+	4.9%	21,421
Totals	18.8%	646,794

Source: *OPS 2000*

Table 1.25: Responses to: "*Number of Months Uninsured in last 12?*"

Age	6 Months or Less	7–11 Months	12 Months	# Uninsured for 12 Months
0–18	47.5%	12.9%	39.6%	56,504
19–64	39.9%	11.1%	49.0%	236,620
65+	32.0%	6.8%	61.2%	13,115
Totals	41.3%	11.4%	47.3%	305,904

Source: *OPS 2000*

While children have a relatively lower risk of being uninsured for long periods of time, more than 56,000 children were uninsured for 12 continuous months in 1999–2000.

1.3 Summarizing the information provided above, what population groupings were particularly important for your State in developing targeted coverage expansion options?

Oregon's research of coverage expansion strategies led us to focus on the following groups:

- Low-income children eligible but not enrolled in CHIP
- Adults, 100%–200% of the Federal Poverty Level
- Low-income working adults who are offered coverage but find it too expensive
- Parents of CHIP eligible children
- Low-income adults with no kids in household
- Oregonians who temporarily lose coverage
- Low- to moderate-income families who cannot or will not enroll for publicly offered health insurance and seek care through the safety net
- Ethnic minorities, especially Hispanic/Latino populations

1.4 What is affordable coverage? How much are the uninsured willing to pay?

Much of Oregon's research suggests that many families with low incomes are stretched financially and unable to afford health coverage. During HRSA grant-sponsored focus groups, uninsured participants shared stories about affordability.[*] Two examples:

> *It is too expensive. It's like two hundred dollars per month for each kid...with all the kids that I have...I will have to give them the whole paycheck for insurance. So, what can I take home? Nothing.*
>
> *Then the nurse told me that I would have to pay for this [ER] visit, as the condition is not an emergency. A week later, they sent me a bill for $650. I was shocked, I can't even think of paying so much money. So, I moved to a different address and did not leave a forwarding address.*

The Household Survey gave some quantitative measure of the financial burden of paying for health care. As shown in Table 1.26, the statewide results suggest that 50–60% of the uninsured had trouble in the last twelve months handling the cost of needed health care:

[*] Please see *www.ohppr.org/hrsa/index_hrsa.htm* for details.

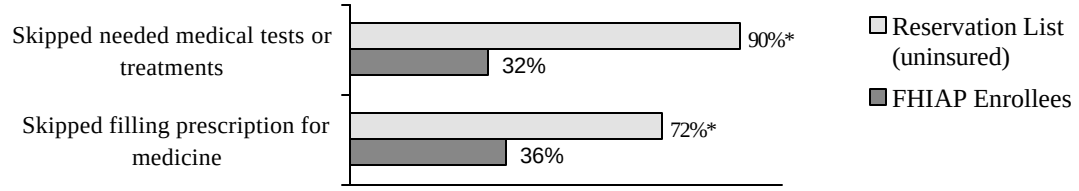
Table 1.26: The Financial Burden of Health Care

"Because of cost, in the last 12 months, have you or someone in your household..."	All	Uninsured
gone without a needed test or treatment?	24%	60%
gone without filling a prescription for medicine?	21%	49%
Had any problems paying medical bills?	25%	51%

Source: *Household Survey, 2000*

The *FHIAP Study* provides further evidence that the cost of health care can overwhelm the uninsured, as shown in Figure 1.C. Those on the reservation list who are uninsured are much more likely to forego needed health care than those who are insured:

Figure 1.C: FHIAP Study—Percent Foregoing Health Care



**Significantly different from FHIAP enrollees (p<.05).*
Source: *FHIAP Study*

There is no easily-drawn line that divides Oregon into groups that can afford coverage and groups that cannot. While health coverage may be expensive, many with low incomes manage to obtain health coverage, even when they have to pay substantial amounts for it. For example, focus group participants (most of whom were below the federal poverty level) expressed a willingness to pay $10 to $30 toward a monthly premium.

The *FHIAP Study* also sheds light on willingness to pay for health coverage. FHIAP provides subsidies to low-income families to purchase private health insurance. Premium subsidies range from 70–95% but families must pay the remaining premium and all cost-sharing. This can be burdensome since all enrollees have incomes below 170% of the FPL. In the *FHIAP Study* we asked respondents to estimate the out-of-pocket medical expenses for themselves and their families, including premiums and copays (see Table 1.27).

Table 1.27: Self Reported Out-of-Pocket Expenses—FHIAP Enrollees

Out-of-Pocket in Last 6 Months	% Enrollees Who Paid This Amount
Less than $50	11.9%
$50–99	12.8%
$100–499	41.4%
$500–999	19.9%
$1000–$1,900	8.1%
$2000 or more	3.6%
Don't know	2.5%

Source: *FHIAP Study*

Almost half of FHIAP enrollees (41.4%) said they paid between $100 and $500 in a six-month period.[*] If the mid point ($300) is used as an estimate of their average cost, then this group expects to pay about $600 a year, or $50 a month. Almost one-third (31.6%) of the FHIAP enrollees pay much more. Yet FHIAP, capped because of limited state funds, has about 5,000 enrollees and a wait list of 20,000 people.[†,‡]

1.5 Why do uninsured individuals and families not participate in public programs for which they are eligible?

Based on OPS data about 115,000 Oregonians have household incomes below 100% of the FPL and are uninsured. Many, if not most of these individuals are eligible for the Oregon Health Plan. But even though they do not enroll in OHP, many still have effective coverage because of the availability of retroactive eligibility. Current application guidelines dictate that individuals who need medical care will receive it from the *date they sign up*, as opposed to the date the application is approved. In effect, this policy extends the effective reach of the OHP by providing health care to those who need it as soon as they need it. It also has the consequence of dampening enrollment in OHP. Since many OHP recipients must pay a small, but real, premium, retroactive eligibility provides a low risk way of avoiding that premium.

One goal of the focus group research was to gain understanding of why many uninsured Oregonians are without coverage.[§] This research provided reasons for not participating, including:

- ***Cost*—**OHP currently is a very low cost program for participants, however it is not free. Enrollees are expected to pay a small monthly premium that varies from $6 to $23 per household.

[*] It is important to note that this cost does not include the subsidy. Without the subsidy, FHIAP members would have much higher costs for premiums.
[†] Please see Section 1.9 of this report for more information about direct subsidies to low-income families.
[‡] Please see "Cost-sharing Strategies for OHP Medical Services," *www.ohppr.org*, for conceptual ideas on how increased cost-sharing for the Oregon Health Plan might positively and negatively affect health care utilization.
[§] Please see *www.ohppr.org/hrsa/index_hrsa.htm* for the complete report of results.

- ***Confusion about enrollment/re-enrollment process*—**As one uninsured focus group participant said:

  It's confusing. Even though I have filled out the form before, I always have to go up to the desk and say 'you need to explain this to me.' Like you have to sign up for a specific organization if you live in a certain area. I don't know...it is really confusing.

  Focus group participants thought the reapplication process was overly complicated. In fact, most uninsured participants felt that OHP renewal should take place annually instead of semi-annually. Many participants described OHP literature as confusing even when it is written in their native language.

- ***Some Oregonians don't know they are eligible for the OHP.***

- ***Lack of clarity about how citizenship status affects eligibility*—**Typically, people who do not meet the citizen requirements have limited eligibility for emergency medical services including childbirth through CAWEM—Citizen Alien Waived Emergent Medical. Diagnostic services and on-going medical treatment, including prenatal and postnatal care are not covered.[6] The focus group research found this to be a significant issue among Hispanics/Latinos, especially when seeking care for childbirth. In the words of one Hispanic woman:

  I thought it was going to cover the whole thing. But they [the hospital] sent me many bills when I had my baby. [These bills were for] the lab-HIV test, pap smears, and stuff. They [OHP] didn't cover that.

  Not only did this limited coverage leave non-citizens at financial risk, non-citizens don't always understand their rights under CAWEM and how it is different from regular OHP coverage.

- ***Dissatisfaction with OHP (including language issues, cultural competency)*—**In the words of uninsured focus group participants:

  [A hospital visit] takes forever, especially if you are on the Oregon Health Plan...every time I go there around three or four in the afternoon, I leave around ten at night. Last year I took my son to the hospital because I thought he had pneumonia. It took forever to admit him. It was very frustrating. I had to fight with everyone there to get him admitted.

  If you are on the OHP, then they will make you a low priority. You'll get the last available appointment.

1.6 Why do uninsured individuals and families disenroll from public programs?

In March 2001 the Center for Outcomes Research and Evaluation completed an Oregon Health Plan Disenrollment Survey.[7] This study represents a critical source of information about why people leave the OHP. The study looked only at those who lost their eligibility, so is limited to involuntary leavers—about 85% of the total who leave OHP. The other 15% could be considered "voluntary leavers" because they technically appear to be eligible when they leave. This group

includes those who were dissatisfied with the program. Table 1.28 looks at those who lost eligibility; most did so because their household income or assets increased beyond OHP thresholds:

Table 1.28: Reasons for Loss of Eligibility

*Went over resources**	62%
Paperwork	16%
Pregnancy Ended	5%
Premium Issues	3%
Moved	2%
Service/Quality	1%
School	1%
Other	7%
Don't know	3%

**98% income related; 2% asset related*
Source: *Oregon Health Plan Disenrollment Survey*

Of those who said their income increased beyond OHP cutoffs, researchers asked why, as shown in Table 1.29.

Table 1.29: Reasons for Increasing Income

New Job	27%
Increased hours at work	22%
Pay raise	11%
Increased disability income	9%
Spouse pay raise or new job	9%
Increased child support	4%
Widows benefit	3%
Other	12%
Don't know	1%

Source: *Oregon Health Plan Disenrollment Survey*

In addition, the HRSA Team just completed a study of why people disenroll from FHIAP (October, 2001).[*] Key findings include:

- Eighty three percent (83%) of those leaving the FHIAP program report incomes under 185% of the FPL.
- Thirty-three percent (33%) of respondents say they leave because their income exceeds the 170% of the FPL eligibility limit.

[*] Please see *www.ohppr.org/hrsa/index_hrsa.htm* for details.

- Even though FHIAP participants must pay significant cost-sharing, this does not appear to be a primary reason for disenrollment: 6% reported a disenrollment resulting from a missed premium payment, another 12% cited either high out-of-pocket costs or lost jobs.
- Income averaging rules for FHIAP eligibility may place individuals and families with seasonal work or uneven income at a disadvantage: 21% of those losing their enrollment because of income-over-allowable limits also report annual incomes of less than 100% of the FPL.

1.7 Why do uninsured individuals and families not participate in employer sponsored coverage for which they are eligible?

As noted in Section 1.2 (Availability of Private Coverage) about 110,000 Oregonians are eligible for employer sponsored insurance (ESI) coverage through their employer but decline such coverage. About 30,000–35,000 have incomes below 200% of the FPL and remain uninsured. The high cost of coverage is by far the single biggest reason people decline ESI.[*]

The Oregon Health Plan Disenrollment Survey provides some additional findings about workers with low income who had jobs that offered insurance coverage (see Table 1.30). Most survey participants had incomes between 100–200% of the FPL.

Table 1.30: Responses to: *"Why don't you participate in your employer's health insurance*

Don't work enough hours to qualify	36%
Premiums too expensive	25%
Haven't worked there long enough	14%
Other	16%

Source: *Oregon Health Plan Disenrollment Survey*

In addition, the focus groups with uninsured Oregonians suggest that many low-income uninsured are hesitant to accept state subsidies for employer-sponsored insurance. They fear that health benefits would be forever linked to keeping their job. For the uninsured who are unemployed or seasonally employed, this would be a bad outcome. Instead this group prefers state-sponsored insurance programs.

The University of Oregon recently completed a longitudinal study of people leaving TANF or food stamp programs and they also found a "pro-public" stance.[8] Their findings suggest that many people prefer public health care programs because they appear to be more stable and to offer more comprehensive benefits. As to any stigma attached to public-funded programs, researchers believe that the OHP has generated sufficient positive press, in part by having the support of a popular governor, to at least partially offset many negative connotations.

[*] Please see Section 1.2 of this report.

1.8 Do workers want their employers to play a role in providing insurance or would some other method be preferable?

Our research suggests that employer-sponsored insurance is popular with the general public and by extension, with workers themselves. For example, the Household Survey asked if Oregonians would favor or oppose various specific approaches for expanding access to health care. Seventy-five percent (75%) said they would favor using state funds to help small employers offer health insurance. Sixty-six percent (66%) went so far as to favor "requiring all employers to offer health insurance." These findings are consistent with national surveys that find high support for ESI.[9]

However, employees still have serious problems, including:

- Perceived lack of choice
- Lack of portability
- Employers who don't offer ESI; typically smaller firms, younger workers, lower wage jobs[*]
- Projections that employee cost-sharing will increase
- Concern about trends toward defined contribution plans
- Projections that workforce demographics will shift in ways to cause ESI offer rates to decline, especially if the number of part time workers increase

1.9 How likely are individuals to be influenced by: 1) availability of subsidies 2) tax credits or other incentives?

Availability of subsidies:

Oregon has gained a great deal of experience with subsidies to individuals through the Family Health Insurance Assistance Program (FHIAP). FHIAP offers state-paid subsidies to low-income Oregonians who are unable to afford health insurance coverage. Enrollees must have been uninsured for at least six months except if they are just leaving the Oregon Health Plan. The subsidies pay 70–95% of the premium costs for health insurance plans offered by employers or in the private insurance market. Enrollees are responsible for copayments and deductibles as required by their selected plan.

By many measures the FHIAP subsidy model has worked well. The program is at enrollment capacity and has a long wait list.[†] The *FHIAP Study* indicates that FHIAP is very popular with participants. In addition, subsidies need to be set at a high percentage level, allowing those with low incomes to participate, and ensuring that enrollees will have access to comprehensive benefit plans.

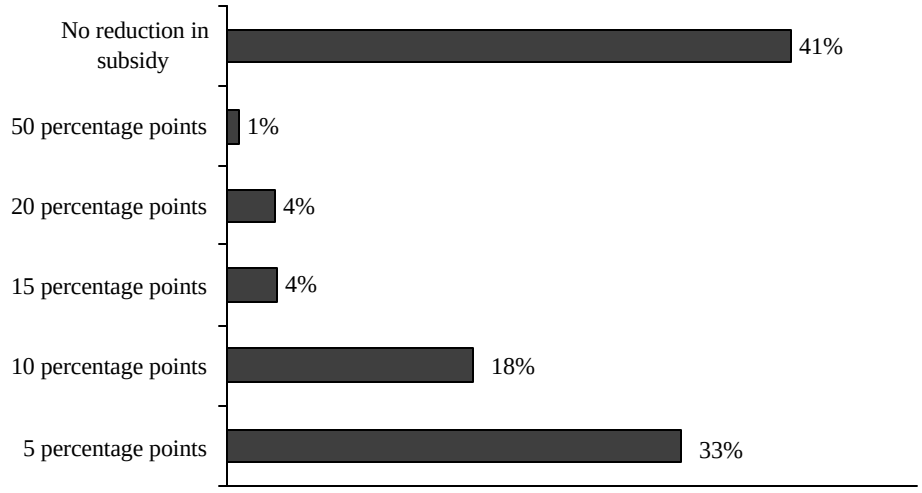
When asked to rate how important FHIAP has been to them in getting access to health care on a 5-point rating scale from *very important* to *not important at all*, 97% said it was *very important*, and the remaining 3% rated it as *somewhat important*. The issue of choice was also very

[*] Please see additional discussion of employer sponsored insurance in Section 2 of this report.
[†] Please see *www.ipgb.state.or.us/Docs/fhiapstats.htm* for enrollment statistics.

important to enrollees. Seventy-five percent (75%) rated having a choice of coverage options as *very important* and 20% rated coverage choice as *somewhat important*.

As part of the *FHIAP Study* enrollees were asked if they could still get by if their subsidy were reduced by various percentage amounts (see Figure 1.D).

Figure 1.D: Willingness to have FHIAP Subsidy Reduced



Source: *FHIAP Study*

FHIAP does not currently receive federal matching dollars and enrollment is capped because of lack of additional financing. However, because FHIAP is so popular with low-income Oregonians (20,000 people on the wait list is the program's best argument for continuation) and because Oregon wants to strengthen public-private partnerships the HRSA Team is looking for ways to expand the program.

Tax credits or other incentives:

Tax subsidy/credit strategies can:

- Improve tax equity
- Strengthen the private insurance system
- Be politically attractive—credits can be seen as a tax cut as opposed to new spending

Even so, Oregon remains skeptical about the use of tax credits to fund the purchase of health insurance for low-income individuals, especially tax efforts that rely completely on state-only funding. In the just completed legislative session only one health care tax credit bill was introduced and it did not receive a hearing.

The major problems with using tax credits to purchase individual coverage include:[10]

- It is expensive to use tax credits as a means of decreasing the number of uninsured.
- Tax credit programs vary in their efficiency (cost per unit reduction in number of uninsured). Important ingredients to improve success appear to be: 1) refundable credits and 2) methods to match the timing of tax subsidies with the timing of insurance payments.
- Some tax subsidy proposals, such as tax deductions, do not adequately target those with low-incomes.
- Tax credits targeted for the purchase of individual coverage will probably lead to reductions in the number of people covered by employer-sponsored insurance.

1.10 What other barriers besides affordability prevent the purchase of health insurance?

The Household Survey asked uninsured respondents why they didn't have health insurance. As Table 1.31 shows, most directly cited economic reasons or their inability to obtain employer sponsored insurance. A few mentioned that they were refused coverage for health reasons and a few mentioned that they didn't need it:

Table 1.31: Reasons for Lacking Health Insurance

Can't afford	49.5%
Unemployed or between jobs	20.0%
Employer doesn't offer to any employees	8.6%
Not eligible through employer	7.8%
Refused coverage for health reasons	1.9%
Too difficult or too much paperwork	1.0%
Don't need it	2.3%
Other	8.9%

Source: *Household Survey*

The *FHIAP Study* also provided insight into why people below 170% of the FPL go without coverage (see Table 1.32). At the top of the list was cost. While most of FHIAP's population is employed, employment does not always lead to health insurance. Sixty-five percent (65%) of those who are currently employed, but uninsured, report that their employer does not offer insurance; another 14% of the uninsured report that they do not work enough hours or have not worked long enough to qualify for employer-sponsored insurance.

Table 1.32: Responses to: *"There are many reasons why people go without health insurance. Why are you (or were you) uninsured?"*

Reason Without Insurance	***Percent Who Cited Reason as a "Major Reason" for Being without Insurance***	
	Enrollees (uninsured prior to FHIAP)	**Waitlist (uninsured while on waitlist)**
Too expensive	94%	94%
Lost Eligibility for OHP	38%	52%
Lost Eligibility for OHP	38%	52%
Employer did not offer health insurance	52%	48%
Unemployed or Between Job	29%	34%
Employment did not offer coverage for dependents	24%	28%
Family member's health insurance did not cover me	17%	23%
Refused Insurance due to pre-existing conditions	17%	12%
Have not worked long enough or do not work enough hours to qualify for ESI	10%	17%
I did not know how to get health insurance	14%	9%
Benefits from a former employer ran out	10%	13%
Became divorced or separated	8%	10%
Did not believe anyone would sell me insurance	8%	10%
My employment is/was seasonal	5%	6%
Did not think I needed Insurance	1%	2%

Source: *FHIAP Study*

1.11 How are the uninsured getting their medical needs met?

Our research suggests that the uninsured are often successful in finding health care, but that they utilize and pay for services very differently than the insured. The Oregon Health Plan Disenrollment Survey provides information about those who lost eligibility for the Oregon Health Plan and how low-income individuals cope with being uninsured.[7] About 71% of those who disenrolled were without health insurance immediately after leaving the OHP. As shown in Table 1.33, those who keep some sort of health coverage are three times more likely to seek out doctor services than the uninsured.

Table 1.33: Responses to: *"Have you visited a doctor for any reason since leaving OHP?"*

	Insured	Uninsured
% Yes	60%	23%

Source: *Oregon Health Plan Disenrollment Survey*

Table 1.34 shows that many low-income individuals who need care but are unable to obtain insurance will switch the location of their care from a private doctor's office to the emergency room.

Table 1.34: Comparison of Usual Source of Health Care when OHP Insured versus Uninsured

	Usual Source of Care while on OHP	Source of Care for most recent visit (after leaving OHP)
Private Doctor's Office	65.1%	* 48.4%
Community/Migrant Clinic	9.0%	7.2%
Hospital Clinic	5.0%	4.5%
Urgent Care Clinic	5.0%	8.9%
County Health Department	4.3%	5.6%
Health Emergency Room	3.1%	* 13.4%
Family Planning Clinic	3.6%	4.5%

** Significant (p<.05) difference from usual source of care. Non emergency visits only.*
Source: *Oregon Health Plan Disenrollment Survey*

The Household Survey also provides a perspective on differences in health care seeking behaviors between the insured and uninsured, as shown in Table 1.35.

Table 1.35: Health Care Seeking Behaviors

	% Yes		
	All	**Uninsured**	**Insured**
Do you currently have a regular doctor or clinic you go to?	87%	45%	92%
In the last 12 months have you received a routine physical exam or check up?	65%	33%	69%
In the last 12 months have you had a problem getting medical care you believed necessary?	30%	41%	29%

Source: *Household Survey*

The *FHIAP Study* amplifies these findings. FHIAP enrollees are more likely to have a regular source of health care than those on the reservation list, and the source of care is more likely to be a private doctor's office or clinic. Enrollees were also more likely to receive preventive services. More specifically:

- Seventy-one percent (71%) of enrollees reported having seen a provider in the last 6 months for regular or routine care while 43% of those uninsured on the reservation list have seen a provider for regular or routine care.
- Ninety-five percent (95%) of the enrollees reported having a regular place to go when they were sick or wanted medical advice; this is true for 72% of those on the reservation list.
- Access to regular or routine care outside of regular office hours is not significantly different for those on the reservation list and those enrolled in FHIAP.
- Eighty-two percent (82%) of the enrollees report using a private doctor's office or clinic for their regular source of care while 56% of the uninsured on the reservation list report the same.
- Eight percent (8%) of the uninsured on the reservation list report using the emergency room as their usual source of care. Less than one-half of 1% of the enrollees report use of the emergency room for regular care.
- Enrollees were much more likely to have received preventive services within the last year. For example, 58% of the enrollees had a routine physical in the last year versus 34% for the uninsured on the reservation list. These differences extended to cholesterol checks, blood pressure checks and Pap smears.[*]

Health care coverage only works if people can actually get appointments for needed care within a reasonable time frame. To learn more about this dimension of access to care, the *FHIAP Study* also asked respondents if they could get various types of appointments as soon as they wanted. Those with insurance were much more likely to have effective access to needed care (including routine care, care for illness or injury and even preventive care):

- Eighty-three percent (83%) of the FHIAP enrollees report they are able to get appointments for routine or regular care "Usually" or "Always"; 64% of those who are uninsured on the reservation list report the same.
- Sixty percent (60%) of those on the uninsured on the reservation list report that they have had an illness or injury in the last 6 months requiring care right away; 24% of those reported that they were "never" able to get care as soon as they needed. Only 2% of enrollees reported that they were "never" able to get care as soon as they needed for illness or injuries.

The *FHIAP Study* examined the effect of insurance status on children, using delivery of immunizations and missed days of school as indicators of possible adverse medical and social impacts resulting from gaps in insurance coverage:

[*] Please see full results at *www.ohppr.org/hrsa/index_hrsa.htm*.

- Fifty-six percent (56%) of those individuals on the reservation list with children report that there was some period of time in the last 12 months when their children were completely without health coverage whereas 14% of enrolled individuals have experienced breaks in insurance for their children in the last 12 months.
- Children in families on the reservation list are more likely to miss days of school because they are not able to get needed medical care. Twenty-two percent (22%) of those individuals on the reservation list with children report that one or more of their children have missed days of school because they were not able to get needed medical care whereas 8% of enrolled families report that their children missed school days because of a lack of needed medical care.

In summary, the uninsured use many coping strategies to get their medical needs met. A short list of their strategies, including quotes from focus group participants when available, are listed below:

- Postpone preventive care services:

  I can't afford health insurance. My ex-husband paid it for 23 years. I am healthy—don't go to the doctor when sick generally but I need general health coverage for exams, etc. I have been unemployed for about 3 months. That is my current status.

- Postpone elective care:

  I am in need of severe dental coverage. My children are in need of physical and dental check-ups. I want to know if we can expedite this coverage so we can get the medical care we need.

- Postpone chronic care treatment:

  My husband is a diabetic. We run into financial hard times with getting his insulin and test tabs. We went without insulin for 2 weeks this month. This is dangerous and compounds his illnesses long term effects. He is doing well overall, but not being able to have a doctor's supervision over him is not smart. We are actively interested in avoiding diabetic complications, but this is challenging without medical health providers.

- Rely on emergency and urgent care facilities:

  I am in a category 'not poverty level', however, not making enough to buy $275 a month health insurance. I'm at an age where I need health insurance. I have one more payment on an ER bill for my significant, and just this week accumulated an urgent care bill. It's sad when the sicker or more severe ailment is the one treated. I'm all for everyone having access to health insurance.

- Rely on safety net and community-based clinics:

  My son attains check-ups etc. for free through [the local clinic].

- Rely on traditional healers or home remedies:

  When someone has a fever, we put cold towels on him or we use herbal teas. Some teas are for stomach aches and things like that. We can't pay to see a doctor just for a stomach ache, so we use these teas.

- Pay for care out of their own pockets:

  We are currently trying to pay off major medical bills for my husband in excess of $1,500. We don't qualify for Oregon Health Plan but can't afford any other insurance. I am diabetic and can't afford my medicines. We are too young for Social Security Medicare. We desperately need health insurance.

- Pay the price for delayed care:

  [My daughter] was uninsured for 6 months last time her OHP lapsed; it took OHP and AFS 4 months to process my application and issue a medical card. In the meantime, she was off her medicine and ended up in a mental health triage emergency room. There is no excuse for that and that's no way to treat children.

- Self treat:

  My husband hurt his hand and needed stitches. We did so at home because he won't put the money out in more bills when the kids need docs themselves.

1.12 What is a minimum benefit?

A minimum, or basic benefit plan, refers to "…health services that should be generally and uniformly available in order to assure adequate health status and protection of the population from disease."[11] Such a plan may represent a minimum set of benefits to be equaled or exceeded by health insurance carriers or it may be the only set of benefits offered. It generally consists of a list of required health care services, clearly defined limitations and exclusions, and a summary of reimbursement limitations such as cost-sharing, maximum reimbursement.

Basic benefit plans are a key element in any health care reform proposal because they can ensure a minimum level of coverage, control costs, and facilitate comparison among plans. The cost of a benefit can be a deciding factor in the public or private insurers' decision to include or exclude it in a policy. Detailed understanding of benefit packages with their limitations of coverage, cost-sharing characteristics, and anticipated utilization is critical to estimate or determine actuarial costs for covered services.

In the summer of 2000, a Task Force on Basic Benefit Plans was created within the Oregon Health Council. The Task Force held public discussions on the issues involved in defining a basic benefit plan. Specifically, they were asked to explore whether the health care needs of the low-income uninsured would be better met by covering a core set of benefits and services rather than remaining uninsured for all services.[*] With the OHP Medicaid expansion covering those up to 100% of the Federal Poverty Level (FPL), the Task Force focused on the uninsured working

[*] Please see "Issues Invovled in Designing a Basic Benefit Package and Determining Actuarial Equivalence" at *www.ohppr.org/hrsa/index_hrsa.htm.*

poor, adults with income from 100–200% of the FPL. Children and pregnant women in this income range would likely be covered under expansions of the State Children's Health Insurance Program (SCHIP) and Medicaid, which currently cover these individuals up to 170% of the FPL.

The Benefit Task Force focused on two types of approaches to benefit design: 1) *access promotion*, a system that encourages early diagnosis through routine health care in order to increase the potential for better outcomes of treatment and reduced costs, and 2) *asset protection*, a system exemplified by a catastrophic plan, which uses copayments and deductibles to shift some of the cost of low-cost care to the consumer, while providing the individual protection from losing their assets due to a severe illness or "catastrophic" event. Most HMO's have traditionally offered fairly rich and complete coverage of both preventive care and catastrophic expenses.

The Task Force reached the conclusion that a basic benefit plan for uninsured adults from 100–200% of the FPL should stress *access promotion*. Concerns were raised that many individuals at this income level would not be able to afford even moderate expenses, resulting in the same outcomes as if they remained uninsured. By focusing on access promotion, there would be enhanced coverage of preventive and early intervention health care, while limiting the coverage of high cost cases. This plan is consistent with the public health goal of encouraging preventive care.

In December 2000, Governor John Kitzhaber directed the members of the Oregon Health Services Commission (HSC) to begin work on defining a standard benefit package that could be used to expand access to non-categorically eligible applicants with household incomes up to 200% of the FPL.[*] The current OHP benefit package, renamed OHP Plus, would continue, remaining available to the most vulnerable population. The second package, named OHP Standard, would be at least actuarially equivalent to the benefit package mandated under Medicaid, with Oregon to request a waiver for federal match. SCHIP legislation currently allows for actuarial equivalent benchmark plans for federal funding.

The Health Services Commission has been exploring benefit reductions and cost-sharing models as it has worked to define a minimum benefit package. The HSC will forward recommendations to the Waiver Application Steering Committee and the Legislative Emergency Board, who will determine what the funding level will be for the new public OHP Standard benefit package.

As outlined in HB 2519, the Insurance Pool Governing Board (IPGB) has been reviewing small-group plans to determine a minimum set of benefits and services that will define the basic health benefit benchmark on the private side. This benchmark will be the standard that a private insurance plan will be compared to in order to qualify for public subsidy. The subsidy will assist currently uninsured individuals up to 185% of the FPL to participate in their employer sponsored insurance plan.

[*] With passage of HB 2519 this was changed to 185% of the FPL.

1.13 How should underinsured by defined? How many of those defined as " underinsured?

The concept of underinsurance attempts to define the gap between what people might rightfully expect from health insurance and what is actually delivered. This is complicated in part because of overlapping and conflicting perspectives. Whether a health benefit is useful or, instead, results in the creation of systematic barriers to needed care depends on a great many things including:

- the degree of financial burden;
- the extent to which the benefit covers what the patient wants;
- how much stigma might be attached to using the benefit;
- an assumption that patients understand and value insurance.

There is also a potential conflict between what is socially desirable and what might be individually desirable. In the early 1990's the framers of the original Oregon Health Plan worked hard to gain public input and create an active debate about such issues. This remains an important value in Oregon.

Oregon has not discovered a definition for the concept of underinsurance, but has outlined a cluster of related ideas:

1) ***Catastrophic illness protection—***In some instances under-insurance can result in financial ruin. This definition seeks to identify those people who are at risk of large out-of pocket expenditures for an unusually expensive, catastrophic illness. To operationalize it, Pamela Short and Jessica Banthin (1995) defined the under-insured as individuals at risk for out-of-pocket expenditures exceeding 10% of their annual family income if they faced the average medical expenses of individuals with the highest 1% of expenditures in their risk group.

2) ***Actuarial value comparable to some standard plan—***Define a benchmark plan (such as the most popular HMO plan in an area or the Federal employee plan) and determine how other plans compare. People who have plans of lesser actuarial value might be considered under-insured.[*]

3) ***Availability of critical benefit features (such as mental health or dental or prescription drugs)—***Does the plan in question include these benefits or not? Do the people using the plan want these features or not? Oregon has used public meetings to learn more about values of Oregonians.

   Focus groups with low-income, uninsured Oregonians suggest that people want comprehensive benefits and will not be easily dissuaded from this perspective. While insurers and employers might see health benefits as a series of modules (dental, pharmacy, mental health) that can be mixed and matched to create lower cost packages, focus group participants resisted such thinking. In fact, many participants

[*] Please see Section 1.12 for our discussion about minimum benefits and Section 3 for information about defining adequate benefits. For a detailed discussion of the actuarial work we did to define an acceptable publicly-funded plan, please also see *www.ohppr.org/hrsa/index_hrsa.htm*.

said they would simply prefer the state to provide low-cost, comprehensive health coverage for all family members.

4) ***Degree of cost-sharing imposed—***At what point does a plan become so expensive that it isn't used? Many studies attempt to define affordability as a maximum percentage of household income dedicated to health care. But what is the appropriate standard?*

   Survey research offers one way to estimate the number of people who feel cost has become a serious burden. Based on the Household Survey we learned that about 20% of the insured go without needed medical services or have trouble with health care costs. (See Table 1.36)

Table 1.36: The Degree to Which Cost of Care is A Burden

"Because of cost, in the last 12 months, have you or someone in your household..."	**All**	**Insured**
gone without a needed test or treatment?	24%	20%
gone without filling a prescription for medicine?	21%	18%
had any problems paying medical bills?	25%	22%

Source: *Household Survey*

5) ***Limits on access to specific services (could be through limitations on pre-existing conditions or number of visits, etc).***

6) ***Degree of stigma attached to the health insurance card—***Some people don't like public assistance programs. Some recipients feel they are treated poorly, some providers don't want public clients because reimbursements are lower or because public clients are perceived as difficult. To the extent this happens, publicly funded insurance can result in underinsurance. Clients stay away, don't understand or follow treatment guidelines.

7) ***Constraint of choice—***health insurance can limit options. To the extent that health insurance forces people into systems they don't like, they might avoid needed care.

8) ***Group coverage versus individual coverage—***Whereas group coverage obtained through an employer might limit choice, an individual policy, with stricter underwriting standards, might impose real burdens on older, sicker individuals. These burdens can take the form of out-and-out inability to obtain coverage, restrictions on benefits and very high cost.

* Please see our discussion on affordability in Section 1.4 of this report.

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Section 2

Summary of Findings: Employer-Based Coverage

2.1 What are the characteristics of firms that do not offer coverage, as compared to firms that do?

Since Oregon has not completed a HRSA-sponsored employer survey, the HRSA Team relied on existing data sources, including:

- *Medical Expenditure Panel Survey;*[1] *and*
- *Kaiser Family Foundation Employer Health Benefits 2001 Annual Survey* (referred to subsequently as *Kaiser/HRET*).[2]

Employer size (including self-employed):

Please see Section 1.1 of this report for information about employer size, including self-employed.

Industry sector:

Offer rates vary by industry type. Kaiser/HRET provides useful information about small firms (3–199 workers):

Table 2.1: Percentage of All Small Firms (3–199 workers) in Which Workers are Offered Health Insurance, by Industry

	2000/2001 Average*
State/Local Government	91%
Transportation/Communication/Utility	83%
Manufacturing	76%
Health Care	73%
Mining/Construction/Wholesale	69%
Service	64%
Finance	59%
Retail	58%
Totals	66%

Source: *Kaiser/HRET Survey of Employer-sponsored Health Benefits: 2000–2001*

* Because Kaiser/HRET's survey data for the percentage of small firms that offer health insurance showed such a dramatic (and unexplained) change from 2000 to 2001, the HRSA Team chose to average 2000 and 2001 results.

Employee income brackets:

Low-income workers are much less likely to be offered health insurance than higher-wage workers. Kaiser/HRET provides some clear evidence: for firms that have more than 35% of employees making less than $20,000 a year, 52% of those firms offer health insurance; for all other firms the combined offer rate is 85%.

Oregon-specific MEPS information provides similar findings: establishments with 50% or more minimum wage employees are very unlikely to offer health benefits (see Table 2.2).

Table 2.2: Establishments with 50% or More Low Wage Employees That Offer Health Benefits

Year	% "Yes"
1996	21.2%
1997	14.4%*
1998	11.5%

Source: *MEPS Oregon-only, private sector*
**Significant decrease from 1996.*

Percentage of part-time and seasonal workers:

Based on Oregon-specific MEPS data, part-time workers in small firms are less likely to be offered health insurance coverage:

Table 2.3: Percent of Private-sector Employees Who Work in Establishments that Offer Health Insurance

Firm Size	Part time	Full Time	Totals
Fewer than 10 Employees	20.7%	49.5%	40.8%
10 – 24 Employees	64.9%	76.5%	74.1%
25 – 99	67.6%	81.4%	77.3%
100–999	97.4%	99.4%	99.0%
1000+	91.0%	99.5%	99.1%
Totals	62.7%	87.5%	83.1%

Source: *1998 MEPS (Oregon only, Private sector only).*

Geographic location:

While Oregon does not have any direct information, county-specific rates of uninsurance and county-specific labor and population estimates suggest an employee-based coverage pattern similar to that shown in Section 1.2 of this report.

For those employers offering coverage, please discuss the following:

Cost of policies:

1998 MEPS data, while somewhat out of date, provide a starting place for discussions about the cost of health insurance in Oregon. Since the apparent differences between small firms and large firms are not statistically significant, the HRSA Team concludes that premium costs are similar across firm size. This is consistent with national data indicating that small employers pay about the same as large employers but get less coverage.[3]

Table 2.4: Average Total Premium per Enrolled Employee—1998

Firm Size	Single Coverage	Family Coverage
50 or fewer Employees	$2,097	$5,373
More than 50 Employees	$2,259	$5,641
Totals—Oregon	$2,211	$5,599
Totals—United States	$2,174	$5,590

Source: *MEPS 1998—Tables II.C.2, II.D.1*

Regarding the trend, the news in Oregon is similar to the news across the country—health care costs are rising sharply. According to a Mercer/Foster Higgins employer survey, Oregon and Southwest Washington large employers (500+ employees) faced a 9% increase in total health benefit costs in 2000.[4] Rates increased faster in Oregon than in the nation (9% versus 6.6% in 2000). According to Milliman & Robertson, HMOs in Oregon raised group premiums an average of 17.1% for 2001.[5]

Other Oregon employers cite much higher rate increases. For example, the Oregon Coalition of Health Care Purchasers absorbed average increases of 22% for health care coverage in 2001.[6] Firms represented by TOC Management Services (500 companies; 100,000 workers) faced 20% increases in premiums for 2000 and 2001; TOC expects the same for 2002 (two thirds of the firms represented by TOC are in wood products, one-third in manufacturing). City County Insurance Services which represents 300 public sector employers (covering about 10,000 workers) reports an overall 12% increase from August 2000–July 2001 and a 25% increase from August 2001–July 2002.

Level of contribution:

Based on MEPS (1998), Oregon employers contribute an average of 90% of the cost of single coverage and 75% for family coverage. Small firms contribute a smaller amount for family coverage than larger firms (66% versus 78%).

Table 2.5: Employer Contribution towards Coverage (Oregon Only)

Firm Size	Single	Family
50 or fewer employees	91%	66.0%
51+ Employees	90%	78.0%
Total	90%	75.0%

Source: *Special tabulations from the MEPS-IC Employer Survey for 1998. Prepared by the Agency for Healthcare Research and Quality.*

While useful by themselves, these numbers need clarification. Most important, they apply only to those employers who offer coverage. In addition, they hide two kinds of variation. First, as point-in-time estimates they don't reveal the trend, and the trend toward more cost-sharing has begun; many employers are asking workers to pay more. As one example—five years ago, according to TOC, the firms they represent made an average contribution of 90% for family coverage; today the average is 50–60%. Second, the summary numbers mask the variation around the mean. For example, as shown in Table 2.6, firms with many low-income workers tend to contribute less than average.

Table 2.6: Average Employer Contribution towards Coverage by Wage Level (Oregon Only)

Wage Level		Single	Family
Low Wage:	more than 50% make less than $6.50/hr	85%	64%
Moderate Wage:	more than 50% make $6.50– $15/hr	90%	67%
High Wage:	more than 50% make more than $15/hr	93%	75%
Other:		89%	84%
Total:		90%	75%

Source: *MEPS Special Run (percent based on plan that was lowest cost to EE all eligibles. 1998 Data)*

Firm size is also an important factor in describing this variation, especially for family coverage (See Table 2.8):

Table 2.7: Average Employer Contribution towards Single Coverage (Western U.S.*)

		Firm Size	
Wage Level		50 or Fewer Employees	51 +
Low Wage:	more than 50% make less than $6.50/hr	76%	77%
Moderate Wage:	more than 50% make $6.50– $15/hr	90%	83%
High Wage:	more than 50% make more than $15/hr	93%	90%
Other:		89%	83%
Total:		90%	84%

Source: *MEPS Special Run (percent based on plan that was lowest cost to EE; all eligibles. 1998 Data)*
**Because of small sample sizes, this information is an aggregate of WA, OR, CA, AK, HI.*

Table 2.8: Employer Contribution towards Family Coverage (Western U.S.*)

Wage Level		*Firm Size*	
		50 or Fewer Employees	**51 +**
Low Wage:	more than 50% make less than $6.50/hr	50%	57%
Moderate Wage:	more than 50% make $6.50– $15/hr	61%	66%
High Wage:	more than 50% make more than $15/hr	67%	76%
Other:		68%	76%
Total:		63%	73%

Source: *MEPS Special Run (percent based on plan that was lowest cost to EE; all eligibles. 1998 Data)*
**Because of small sample sizes, this information is an aggregate of WA, OR, CA, AK, HI*

According to MEPS data (Table 2.8), low-income workers in small firms pay, on average, 50% of the premium for health insurance for families. This can be a considerable burden on low-income families. According to 1998 Oregon-specific MEPS data, the average annual employee contribution for single coverage was $197.84 and for family coverage was $1079.61. Employee contributions are even higher in firms that have a high concentration of low-income workers; employee contributions average about $1,900 per year for firms that have more than 50% low-income workers.

Table 2.9 presents a "what-if" scenario, an estimate of the financial burden those with low incomes face *if* they choose to pay for insurance offered through their employer. Obviously many do not accept the offer. While single coverage seems to be manageable, the cost of family coverage, assuming it is available, amounts to a significant portion of household resources. And these numbers only address the burden of premiums, not any additional cost-sharing such as copayments or deductibles. Nor do they take into account the recent double digit premium increases.

Table 2.9: Percent of Annual Income needed to cover average employee contributions: Family of 3, at 100% and 185% of the FPL

		Percent of the FPL	
	Avg. Employee Contribution per Year	**100%**	**185%**
Single Coverage	$197	1.3%	0.7%
Single Coverage (low-income only)	$262	1.8%	1.0%
Family Coverage	$1,079	7.4%	4.0%
Family Coverage (low-income only)	$1,900	13.0%	7.0%

Oregon's focus group research provides another source of information about contribution levels.* Among owners of small companies (fewer than 25 employees) who participated in the focus groups, the average contribution for single coverage was 50–60%, which is lower than the MEPS estimates. In the words of one small business owner:

> *Most of our employees are in their twenties. So they're a fairly young group and most of them don't really think about health insurance that much. But we have a few in their forties too. They think about it. We decided that the company would pay 60% of the medical and the employee would have to pay 40%, plus dental and vision. So, it's about a fifty-fifty effort at this point.*

Percentage of employees offered coverage who participate:

Please see Section 1.1 of this report, especially Table 1.17 (eligibility and take-up rates by firm size).

2.2 What influences the employer's decision about whether or not to offer coverage? What are the primary reasons employers give for electing not to provide coverage?

Oregon's focus group research reflects the findings of the Kaiser/HRET Benefits Survey (2001):

Table 2.10 Reasons Small Firms (3–199 workers) give for not offering Health Insurance

Reason	Percent "Very Important"
High Premiums	64%
Employees Covered Elsewhere	56%
High Turnover	21%
Company can't qualify for group rates	22%
Obtain good employees without offering a health plan	30%
Administrative hassle	22%
Firm too newly established	6%

Source: *Kaiser/HRET Survey of Employer Sponsored Health Benefits: 2001*

Cost is certainly the biggest barrier to offering health care benefits. As a participant in one focus group with owners of small businesses said:

> *Providing employee health coverage is a concern. I would like to be able to do it. It has not been an option for me so far. I spend every dime that comes in that door. I spend it on wages and taxes, parts purchases, rent and the general overhead...so, really, providing insurance for employees has not been an option. We're getting closer to that point...I might be able to do it sometime soon.*

* Oregon completed six focus groups with small employers. Please see *www.ohppr.org/hrsa/index_hrsa.htm*.

Another participant gave a sense of the relative importance of offering health coverage:

> *Employee health coverage is definitely an important issue, but certainly not the top priority. The top priority is to keep the business running so they have a place to work. So we all have a place to work. Once we managed to get the business running, it was important to get into some kind of benefit program. We though it was more important to cover health care rather than a retirement program. [But even with this program] when the ninety-day limit comes up and [employees] have to enroll, some of them say, "Do I have to?" because it's 50% [contribution policy]. So for healthy employees in their twenties dishing out that much money...doesn't make a whole lot of sense.*

A third spoke to the issues of a mobile and temporary work force:

> *Well, you know there are so many variants. I mean, is that person working full time? Is that person going to be working year around? In numerous cases, I don't think insurance is necessary. A lot of times the employees we have here are on a temporary basis and they don't care if they have insurance. They certainly don't expect it. So that is not a concern. Other people have insurance through their spouses. For us it would be an extra expense we could not afford.*

Conversely a fourth employer thought that by offering health benefits he could, at least marginally, improve the stability of his work force and decrease his recruitment and training costs:

> *I think providing health care attracts more stable people...We're such a low paying industry that we are not going to have a lot of career people so if you can hold on to somebody for just a few extra months by providing them with some insurance benefits—that means a lot to us.*

2.3 What criteria do offering employers use to define benefit and premium participation levels?

Employers are constantly reading the labor market, trying to find the right mix of wages, benefits and working conditions that will attract new workers and keep valued senior workers. Oregon's research pointed to four key criteria:

- Cost of offered care
- Profitability of the firm, which is related to length of time in business
- How easy/difficult it is to attract qualified workers in the local labor market
- Industry norms

2.4 What would be the likely response of employers to an economic downturn or continued increases in costs?

Oregon is already experiencing both problems. Unemployment increased to 6.4% in September 2001, its highest level in seven years and giving Oregon the second highest unemployment rate

in the U.S.[7] Health care premiums continue double digit increases. As a result, Oregon believes that:

- Employers have already begun cost-shifting to employees.
- Employers have begun to limit employee choice of health plans.
- Given the high cost of family coverage and given that some insurers require 75% participation among all eligible employees and dependents, some employers might begin offering employee-only coverage.
- Newly established businesses may delay offering health coverage.
- Firms might reconsider defined-contribution plans. While not yet popular, many employers have a wait-and-watch attitude. Some employers think that use of defined contribution plans could snowball if a few key industries adopt the concept.
- Firms will continue to shop for low cost health insurance alternatives.
- Firms will show more interest in purchasing pools.
- Employers will be more open to public solutions.
- Employers might again become interested in plans that have limited provider panels.
- Firms will be less likely to self-insure. HIPAA privacy laws will require a heavy administrative burden on self-insured employers. Cost of reinsurance/stop-loss has sky-rocketed.
- Some firms are considering the use of "company-doctors."

2.5 What employer and employee groups are most susceptible to crowd-out?

In general Oregon's qualitative research suggests that employers would be hesitant to drop coverage for employees simply because publicly funded coverage options were available. The HRSA Team was consistently told that coverage is an important part of an overall compensation package and a necessary way to attract workers.

Oregon does not necessarily believe crowd-out is a huge problem, especially for individuals under 185% of the FPL. But to the extent it is likely to happen, firms with a high proportion of low-income workers will be most susceptible. Though many such firms could be expected to drop coverage even if there is no public alternative because the high cost of coverage could simply prove to be too much of a burden.

Crowd-out isn't driven solely by employer decision-making. Employers might, in good faith, continue to offer coverage even when new public options come into existence only to see low-income workers opt for the public program. It is also possible that low-income workers would keep their own coverage but use public options to cover the rest of their family.

2.6 How likely are employers who do not offer coverage to be influenced by:

Expansion/development of purchasing alliances?
Individual or employer subsidies?
Additional tax incentives?

Expansion/development of purchasing alliances?

The focus group participants had mixed opinions about purchasing alliances. Almost all the participating employers liked the idea of alliances if such cooperative arrangements could lower costs. However many employers remain skeptical about their potential in this regard. Some employers cited the high administrative costs associated with insurance alliances as a serious barrier to lower costs. Others mentioned the need for long-term participants in the alliances and felt that most small businesses are too transitory; as a result alliances could easily collapse, especially during an economic downturn. Finally, most small business owners want their employee health care plans to be tailored to the specific needs of their few employees and to fit with their own business needs. As a result, small employers tend to perceive larger alliances and insurance pools as limiting their choice for health coverage.

Individual or employer subsidies?

Oregon's research suggests that employers are interested in subsidies. As one focus group participant stated:

> *...so many bigger companies offer [health coverage] and a lot of people with families say that is the biggest thing they look for in a job. They say that they have to have health insurance before they would consider a job. And if you are employing the head of the household, definitely. So if we as small business employers were given an opportunity like tax breaks or a subsidy; it would be extremely helpful. The only realistic way most small businesses are going to be able to give health insurance to their employees is if we do it in cooperation with the government.*

Employers also seem to worry about mandatory participation rates imposed by insurers. Typically employers are expected to enroll 75% of all eligible employees and eligible dependents. As the cost to the employee goes up, participation goes down (family participation especially). Subsidies could help stabilize the situation.

Subsidies to support the purchase of ESI could flow to the employer or the employee. Generally, employers seem to prefer administratively simple subsidies. They don't want to have to create a new audit trail, worry about tax implications and keep tabs on how much their employees have in the way of financial resources. Therefore most employers seem to like subsidies aimed at supporting employees directly.

Additional tax incentives?

Small employers who participated in the focus groups seem interested in tax credit approaches. However, many small employers do not seem to understand the existing tax implications of offering health insurance to their employees.

2.7 What other alternatives might be available to motivate employers not now providing or contributing to coverage?

Oregon believes that a well organized subsidy program will improve offer (sponsorship) rates. According to Garrett, Nichols, Greenman,[8] "Sponsorship and take-up are correlated, which implies that underlying worker demand—and willingness to pay—for health insurance is a key part of firm-sponsorship decisions." To the extent this is true, an expansion of the FHIAP subsidy program could have a positive affect on employer offer rates. If employees come to believe they could afford coverage, with the help of the subsidy, they might begin to ask employers to offer that coverage.

In addition, some uninsured do not currently value health insurance. If the state follows through with the recommendations of the HRSA team to educate people about the reasons to become insured, this too will exert pressure on employers to offer.

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Section 3

Healthcare Marketplace: Summary of Findings

3.1 How adequate are existing insurance products for persons of different income levels or persons with pre-existing conditions? How do you define adequate?

How adequate are existing insurance products for persons of different income levels or persons with pre-existing conditions?

There are several ways for people in Oregon to obtain health insurance products regardless of their income or pre-existing condition. Oregon offers the Oregon Health Plan (OHP) designed to promote access to quality healthcare services. More than 1,000,000 people have gained access to healthcare during the last decade as a result of the OHP. Each of the OHP products provides a means for Oregonians to obtain health insurance in turn providing access to quality healthcare. Oregonians can access several products, including:

- OHP—Medicaid and Children's Health Insurance Program
- Family Health Insurance Assistance Program
- Oregon Medical Insurance Pool
- Small Business Purchasing Pool

OHP—Medicaid and Children's Health Insurance Program

The OHP Medicaid package is available to anyone who qualifies for Temporary Assistance for Needy Families, Aid to the Blind, Aid to the Disabled, and Old Age Assistance benefits, as well as children in foster care and some adopted children. Low-income Oregonians are eligible for coverage if their income is less than 100% of the Federal Poverty Level (FPL). Pregnant women and children through the age of 18 may qualify for OHP Medicaid or CHIP if their household income is less than 170% of the FPL. There is no pre-existing conditions exclusion period as a prerequisite to coverage. Once OHP eligibility is determined it continues for six months before renewal is required. Some OHP enrollees are required to pay monthly premiums of $6–$28 based on income and family size. OHP—Medicaid and CHIP cover medical, dental care, pharmaceuticals, mental health and chemical dependency services.

Family Health Insurance Assistance Program

The Family Health Insurance Assistance Program (FHIAP) has addressed the needs of lower income employees who have difficulty affording premium costs of healthcare coverage. FHIAP has a sliding scale subsidy set by incomes up to 170% of the FPL. It does not, however, assist with out-of-pocket costs such as deductible, coinsurance or copays. In addition to subsidizing some group market plans, there are seven participating individual insurance market carriers for FHIAP. They were selected through a competitive Request for Proposals process. Key requirements were participation in other Oregon Health Plan programs and availability of

comprehensive major medical benefit packages. FHIAP requires six months of uninsurance. The plans that FHIAP participants choose using the state subsidy may have their own specific exclusions. Approximately 80% of FHIAP enrollees are subsidized for individual coverage. With few exceptions, most of these individual plans have a six-month waiting period.

Oregon Medical Insurance Pool

Oregon established the Oregon Medical Insurance Pool (OMIP) in 1989 to provide access to health insurance for people facing benefit limitations because of pre-existing conditions, or for those refused insurance coverage by commercial carriers. Since its inception, more than 23,000 people have gotten insurance through OMIP, with 7,305 currently enrolled.[1] Several insurance plans are available through OMIP: traditional indemnity (fee-for-service) coverage, a preferred provider plan, a managed care plan, and a portability plan. Nearly 70% of OMIP participants have been denied coverage elsewhere, while about 20% would have faced benefit limitations from commercial insurers. Some insurance companies have tightened up underwriting criteria, and the OMIP has seen increasing enrollment due in part to these rejections. There are 1,147 OMIP enrollees whom have their premiums subsidized by the state through FHIAP.

Premiums for each OMIP plan cannot exceed 150% of the premiums charged for typical employer-based group health insurance. As of October 1996 the premium cap changed to 125% of that charged for a typical "portability" product. All health insurance companies doing business in the state are required to participate in the high-risk pool in proportion to their share of the state's commercial health insurance market. The plans are assessed six months in advance for expected losses relative to the premiums paid by program participants, and reassessments are made at the end of each six-month period based on the actual experience of the high-risk pool. Although the state administers the pool, the cost of the claims is borne by subscribers and insurance companies. Besides individual premium contribution, OMIP is funded through an assessment on insurers, re-insurers and self-insurers, allowing contribution based on every non-public covered life in the state.

Small Business Purchasing Pool

Oregon created a small business purchasing pool resulting in more affordable coverage for Oregon's employers and employees of small businesses. Furthermore, Oregon chose to promote the availability of health insurance coverage for workers in small businesses through the creation of small market insurance reforms which include guaranteed issue and renewal of health insurance, pre-existing condition clause restrictions, minimum benefit package requirements, community rating, portability requirements, and extension of small employer reforms to the individual market.

Each of these components of the Oregon Health Plan have demonstrated adequacy in several ways. In addition to hundreds of thousands of Oregonians gaining access to quality healthcare, the percentage of Oregonians with either public or private health insurance rose from 83% in 1993 to 90% in 1999. Hospital charity care has reduced by 30% and emergency department usage has dropped by nearly 10%. Waiting lists for alcohol and drug treatment reduced by 85% from 1994. Furthermore, the OHP members report a high level of satisfaction with services and access to care. Because of the success of these existing insurance programs, Oregon realizes the need to offer similar products to more Oregonians.

How do you define adequate?

Although a great deal of research has been focused on the uninsured and access to healthcare, there has been less focus on the insured and their adequacy of coverage. The elements of a benefit package that are considered adequate are often expressed in laws that mandate coverage. Each state requires certain specified benefits that must be included in insurance policies sold in that state. Federal mandates also set requirements for those not covered by state laws, such as self-insured plans. Some states waive their mandates, creating a "bare bones" insurance policy in order to make insurance more affordable to the uninsured.*

Adequate coverage has been defined as:

> *…a less comprehensive set of benefits, …[and] the beneficiaries are liable for designated amounts of out-of-pocket expenditures in the form of deductibles, copayments, exclusions, limits-of-coverage, and other forms of cost-sharing outside of premiums. Ideally, the amount of cost-sharing is designed to discourage inappropriate utilization of services, while not limiting access to their appropriate use.*
>
> *—Bashshur, Smith and Stiles, 1993*[2]

Generally, benefits coupled with cost-sharing determine the adequacy of health benefit plans. The range of benefits covered and cost-sharing decisions impact access to and adequacy of healthcare services from the perspectives of both consumers and healthcare providers. That is to say that benefits and cost-sharing affect how healthcare is accessed and how it is provided. Access is achieved by having needed services available, in an acceptable manner, at an acceptable cost, and within an acceptable distance and time.

Defining what benefit is "needed" is a matter of debate among some stakeholders. Defining "adequate" is also debated and varies for different populations. It is important to note, however, that not every benefit limitation, in terms of exclusion equates an inadequate insurance product. A benefit package can be determined adequate if it is deemed to meet the protection needs of the insured population.[2] Health insurance covers both predictable and unpredictable events, as well as needed and unneeded services. Adequate insurance benefit design balances these events and needs, while still providing access to healthcare.

Cost-sharing aspects of a plan contribute to the adequacy of a plan. As health insurance premiums rise, Oregon and many employers struggle with cutting or eliminating health benefits, or shifting more costs to the recipient or employee in order to afford insurance. It is anticipated that more Oregonians will face increased out-of-pocket costs for medical care, as well as assume a greater share of the cost of monthly premiums in both the private and public sectors. Whether cost-sharing is considered too expensive depends on what standard is used for comparison and the income of the beneficiary. Low wage earners are most sensitive to cost-sharing increases. The overall cost of a benefit plan can be a major element determining if a beneficiary's insurance coverage is adequate for them and their families.

* Section 1.12 of this report discusses a "minimum benefit."

An additional component that is important to consider when exploring the adequacy of a benefit plan is the implementation of the coverage. If there are significant barriers to access due to the administrative structure of a plan then beneficiaries may perceive that the coverage is inadequate.

In Oregon, the OHP continues to be the basis of defining adequacy of coverage for the public insurance market. The OHP Prioritized List of Health Services has functioned as a mechanism for defining a benefits package as well as a rationing instrument. The OHP benefit package gives high priority to prevention, early treatment of disease, comfort care for the terminally ill, and maternity and newborn care. The inclusion of Mental Health and Chemical Dependency (MH/CD) services into a single integrated benefit package, along with the introduction of a managed care delivery system, are unique to the OHP Medicaid Demonstration. Parity with medical services for MH/CD and dental benefits is beyond most current efforts at the national level for Medicaid populations.[3] The OHP Prioritized List is used by managed care health plans that participate in the Medicaid Demonstration within their benefit plan structure. However, most health plans have not gone to the same level of parity in their commercial plan packages because of cost concerns.

Currently, Oregon is looking at the adequacy of "less rich" benefit packages than its current OHP plan offers so more Oregonians can gain access to healthcare and the current OHP programs can be preserved. Oregon asserts that an adequate, but less rich insurance benefit package can:

- Limit excessive and inappropriate utilization of the health delivery system;
- Keep premiums affordable for consumers;
- Contain costs; and
- Provide financial savings that can be devoted to insuring more Oregonians.

3.2 What is the variation in benefits among non-group, small group, large group and self-insured plans?

Individual and small group:

The Small Employer Carrier Advisory Committee (SECAC) was established in 1991 with the task of designating benefit levels, cost-sharing, exclusion and limitation provisions for the guaranteed issue health plan to be offered to small employers. In 1995, it was renamed the Health Insurance Reform Advisory Committee (HIRAC) and its membership expanded to include insurance agent, labor and consumer representation. Its tasks included:

- Assessing the feasibility of updating basic health plans
- Design of a low cost and prevailing benefits health plans for the portability market
- Design of a standardized health statement for the individual market and late enrollees;
- Development of standardized exclusion periods for specific services

This has evolved into the Small Employer Health Insurance (SEHI) market product and portability standard benefit plans. With the passage of HB 2519, HIRAC is consulting with the Insurance Pool Governing Board (IPGB), which is developing OHP2's private side basic benefit

benchmark plan. HIRAC will continue to influence commercial benefit design, especially for employers with 50 workers or less, part of the expansion target population.

The IPGB, initially developed in 1987 to help small group and self-employed Oregonians gain access to health benefit coverage, has been a key player in stabilizing the individual market through FHIAP and OMIP. They have been asked to determine the basic benchmark plan(s) and certify plans that will qualify for premium subsidy. Their analysis and the potential of additional HRSA sponsored research will provide Oregon with more information about the variation in benefits in the small group market.

Variation in benefits among large groups:

Oregon's large groups have had a variety of benefit packages to offer their employees. With managed care's presence in the state since the 1980's, HMO's have been prevalent with an emphasis on preventative services and low cost-sharing. As mentioned above, there has been a shift towards increased cost-sharing with more employers choosing PPOs. Employers soon will have the options of EPOs with their exclusive provider networks and higher employee out-of-pocket expenditures.

The Oregon Coalition of Health Care Purchasers (OCHCP) is in the development phase of bringing direct care purchasing into the Oregon marketplace, based on a successful model pioneered in Minnesota, the Buyers Health Care Action Group (BHCAG). Employers will be directly contracting with provider systems, selecting based on cost and quality. Each provider care system will have a common set of benefits, using a PPO design with varying levels of deductibles and copays. Employers would subsidize healthcare costs by making a defined contribution for their employees. Employees may make a purchasing decision for higher cost alternatives, although in BHCAG's experience, the care systems with highest quality scores are consistently found in the mid-range and lowest cost tiers. OCHCP has organized an advisory board of purchasers and providers that will focus on issues such as quality plan design and service.

Another version of direct purchasing emerging in the group market is Myhealthbank, based in Portland, which has been signing Oregon employers, mostly mid-sized firms. The employees purchase coverage using funds in their designated accounts, in essence directing their own benefits structure. Employees would receive a set amount of money and would select a health plan of their own, spending as little or as much as they choose based on their health, risk level and dependents' needs. Working in partnership with Regence BlueCross BlueShield of Oregon, Myhealthbank will introduce a flexible spending account (FSA) system. The FSA allows workers to "bank" and carry forward unused health benefit dollars. Leftover money could be invested in a medical savings account against future healthcare expenses, spent on purchasing stock options or taken home in the paycheck. Myhealthbank will move into six other markets outside Oregon in 2001. Some companies have been able to increase choice and even add dental coverage.[4] There may be concern if the employer contribution does not cover the higher costs of insurance adequately in the individual market. By moving to a fixed dollar contribution, the employer may cover the full premium of a lower priced plan, but have employees pay more for a higher priced plan. In this case, more low-wage workers would be likely to take up insurance.

However, this lower-priced plan may have more restrictions, reduced benefits or higher deductibles.

Individuals leaving group coverage may opt for portability coverage whether or not they have exercised their rights under federal or state programs. Oregon is one of only 13 states that adopted portability plans, with a more favorable requirement of only 6 months of previous coverage than the federal requirement of 18 months.

Self-insured:

As interpreted by the courts, the Employee Retirement Income and Security Act (ERISA) of 1974, precludes self-insured plans from state regulation including reserve requirements, mandated benefits, premium taxes, and consumer protection regulations. A Minnesota study found that benefit packages offered through self-funded plans are quite similar to fully-insured plans, despite not being bound by state mandates.[5] Yet some small businesses turn to self-insurance for some cost savings to avoid some of the costs associated with process mandates.

How OHP benefits compare to commercial plans:

As the Health Service Commission (HSC) considers how to balance benefit priorities with cost-sharing in a new OHP benefit package, the HRSA Team was asked to compare the current Prioritized List to commercial plans available in Oregon. This comparison was done in terms of benefit inclusions, exclusions and limitations.[*] Cost-sharing impact was not considered in this comparison. The conclusions were:

- Commercial plans rely on exclusions, limitations of benefits and cost-sharing to define benefits, while the OHP Prioritized List relies on explicit ranking of services. Even though the approaches differ, the practical impact may actually be quite similar.
- OHP is most similar to commercial HMO or PPO benefit policies, due to their mutual emphasis on prevention.
- OHP includes dental and vision, while most commercial products sell these services under separate policies.
- The commercial plans have significantly more limitations on specific benefit services than OHP, while OHP excludes by diagnosis and service.

  However:

  - Thirty percent (30%) of the cost of condition/treatment pairs below the funding line in OHP is similar to commercial exclusions.
  - Thirty percent (30%) of the cost of condition/treatment pairs below the line in OHP is defined as futile care that could correspond to the commercial language of "not medically necessary."

[*] See "Crosswalk Between OHP and Commercial Insurance" at *www.ohppr.org/hrsa/index_hrsa.htm*, under Briefing Papers.

- Í Sixteen percent (16%) of the costs of condition/treatment pairs below the line in OHP are self-limiting conditions, which are covered for diagnosis by both OHP and commercial. OHP denies further services, while these conditions don't incur further significant commercial service or expense.
- Í Only 23% of the costs of the OHP exclusions don't easily correspond to commercial exclusion language.

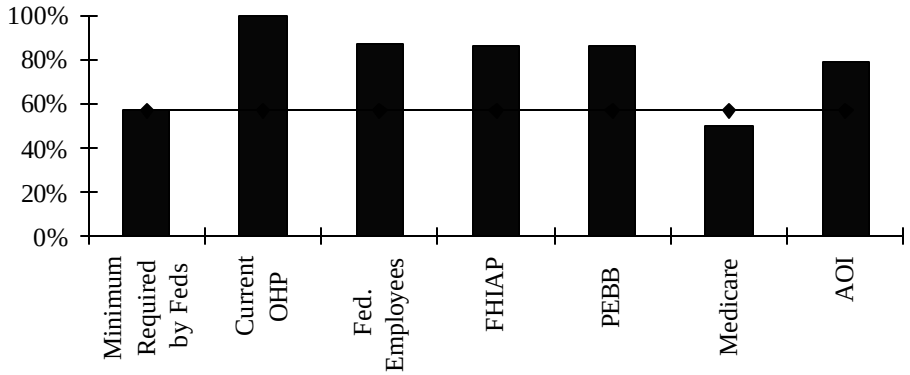
- While there are notable benefit similarities between OHP and commercial plans, the various cost-sharing aspects of the commercial plans are dramatically different from the minimum premium contributions of some OHP enrollees.

Actuarial comparison of benefit plans:

Oregon worked with the actuarial firm of William M. Mercer, Inc. to further develop benefit models that build upon the benefit values and cost-sharing options. Starting with the federal Medicaid mandated benefits outlined in the Social Security Act and the current OHP benefit package, multiple plans were compared to these standards. The database included the current OHP "new eligibles," adults without disabilities up to 100% of the FPL. This portion of the current OHP population might be best suited for a more basic plan while people with disabilities, children, pregnant women, and people getting cash assistance would retain the current OHP package. It was an approximation of an expansion population of the low-income uninsured above 100% of the FPL.

The actuary modeled the actuarial equivalence of the various plans for comparison.[*] A variety of plans were analyzed in comparison to the current OHP package, including large employers such as Oregon's Public Employees Benefit Board, small employer plans such as those offered by the Association of Oregon Industries (AOI), and public-sponsored plans such as the most common selected plan on FHIAP and OMIP. Medicare was significantly less rich in benefits, while most of the other plans were about 20% less rich than the OHP (see Figure 3.A).

Figure 3.A: Actuarial Comparison of Various Plans to Current OHP



[*] A summary of the actuarial comparisons completed by Mercer as well as a summary of Mercer's assumptions, costs and utilization data is available at *www.ohppr.org/hrsa/index_hrsa.htm*.

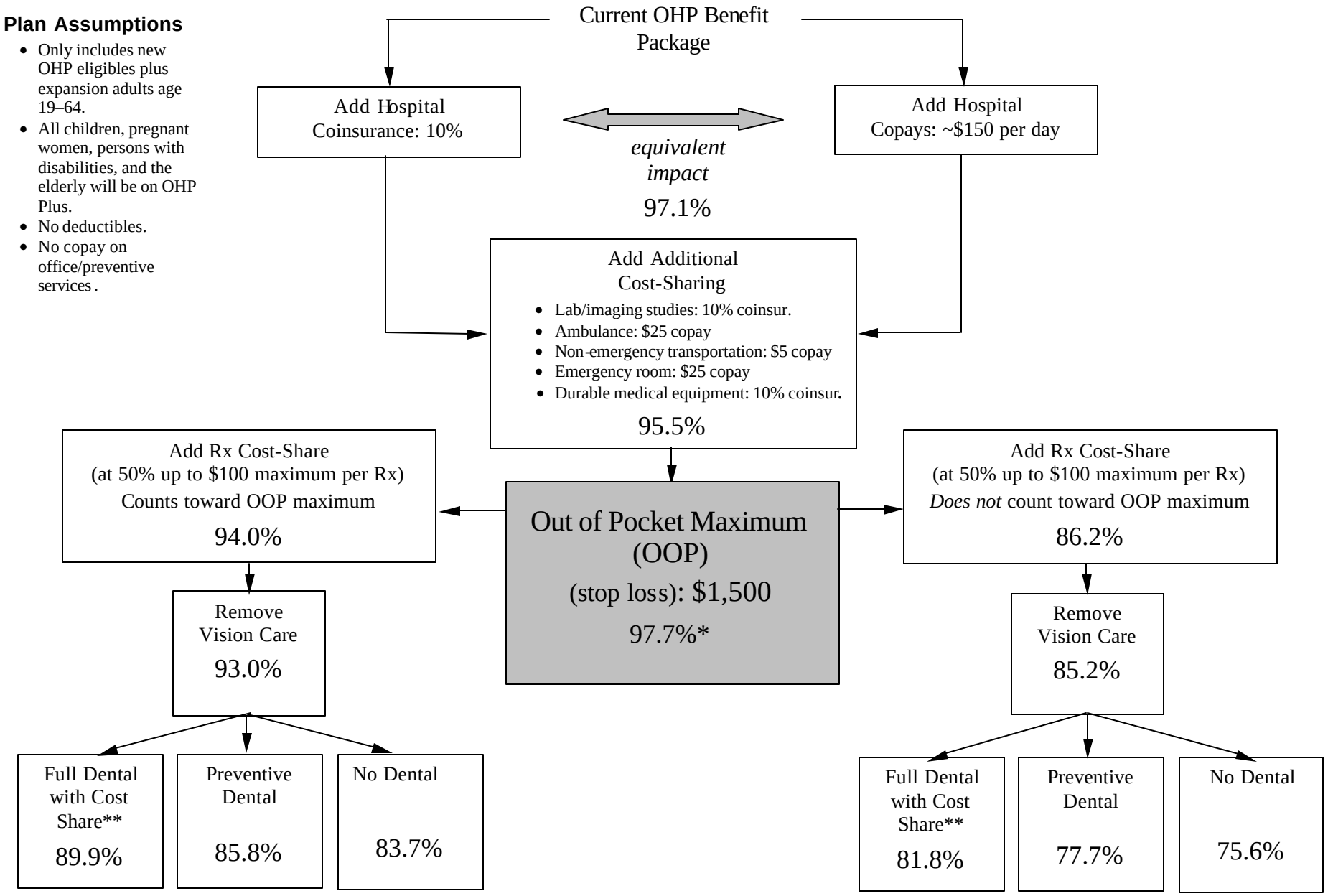
The Health Services Commissioners also asked for modeling of various cost-sharing options, including co-insurance, out-of-pocket maximums, and deductibles. They compared different plans to their comparative actuarial value with OHP, which has very little cost-sharing. A multitude of scenarios were used to see how the different cost-sharing elements affected the overall actuarial value. An example of the process is shown in Figure 3.B.

HB 2519[*] outlines the approach the Health Services Commission will pursue in defining the new "OHP Standard." As HB 2519 is implemented, Oregon's aim is that the new benefit package be about 20% less rich than the current OHP package, which will make the new OHP Standard comparable to the majority of private health insurance plans offered in the state. This similarity is important since Oregon plans to use employer-sponsored insurance as part of its expansion and the similarity would help prevent crowd out, allowing most plans to match a benchmark basic benefit package.

The HSC will continue work on prioritizing the benefit categories based on community values, building up from the federal Medicaid mandates benefits, using the completed actuarial data and the public input from the recent community and stakeholder meetings.[†] By reducing benefits from the current OHP for this population of the "new eligibles" Oregon will be able to extend coverage to additional Oregonians who otherwise would have no benefits coverage at all

[*] A copy of HB 2519 can be found at *www.leg.state.or.us/01reg/measures/hb2500.dir/hb2519.en.html*.
[†] See Public Meeting Summary at *www.ohppr.org/hrsa/index_hrsa.htm*.

Figure 3.B: Actuarial Impact of Benefit Decisions



*Limiting OOP decreases impact of previous cost-sharing

**20% coinsurance 1,000 OOP max

3.3 How prevalent are self-insured firms in your State? What impact does that have in the State's marketplace?

Prevalence of self-insured firms in Oregon:

Oregon does not have specific data on source of funding for Oregon employer-based health plans. Discussions with the staff of the Department of Consumer and Business Services suggests that Oregon does not differ from the country as a whole in regards to the incidence of self insurance among employers.

Reports published in 2000 from the Employee Benefits Research Institute and the Kaiser Family Foundation/Health Research and Educational Trust paint a similar picture of self-insurance. More than 60% of large employers (>500 employees) are self-insured, while fewer than 5% of small employers (<50 employees) are self-insured.[6,7] This trend results in almost 50% of employees insured via self-insured approaches. Two-thirds or more of employees insured via indemnity plans or PPOs are self-insured. Self-insurance involving HMO arrangements are less than 20%, relatively rare.

Oregon has a higher percentage of small businesses and HMO penetration than the rest of the nation. However both trends have decreased in the last two years. Self-insurance will likely occur more frequently as companies seek to respond to large premium increases and HMOs become less popular. One of Oregon's largest HMOs, Providence Health Plan is making a transition from an HMO to a PPO. Some of the large employers they serve will likely move employees to a self-funded option. The Health Care Purchaser Coalition is helping to introduce the direct purchasing option to the Oregon market similar to the Buyers Health Care Action Group (BHCAG) model in Minnesota. This option also works best with self-funded employers.

Self-insurance is also a relative term. Almost all self-insured companies acquire reinsurance for all or some of their health benefit plans. Frequently HMOs insure a portion of employees of self-insured firms. Insurers also provide "alternative funding arrangements" for some large employers that allow for some features of self-insurance. Surveys regarding these issues are inconsistent in their treatment of exceptions causing significant uncertainty about the actual extent of self-insurance.

Impact of self-insured firms in Oregon on the state's marketplace:

It is believed that most self-insured plans have relatively comprehensive benefits and high employer contribution rates, particularly among high tech employers and school districts. Some self-insured employers, cities and counties for example, employ significant numbers of low-income employees and may be experiencing a decline in contribution rates due to increasing costs and declining budgets. The HRSA Team is currently collecting data, hoping to have more complete information in Fall 2001.

Regarding the OHP2 expansion, Oregon is developing a system of group coverage benchmarks to use in determining which employer-sponsored insurance benefit plans qualify for subsidy. The benchmarks will likely include two components:

- A pass/no-pass component testing the inclusion of the "core benefits" that must be covered, and
- Limits on cost-sharing, maximum out-of-pocket expenses, stop loss, and deductibles. These standards will be determined using analysis of the current market place.

While self-insured plans are not required to follow state mandated benefits, the impression from interviews with insurers is that in most cases they do so. Potentially many self-insured employers have low-income workers who cannot afford larger premiums or other cost-sharing contributions often required for richer benefit plans.

3.4 What impact does your state have as a purchaser of health care (e.g., for Medicaid, SCHIP and State employees)?

The Public Employees Benefits Board (PEBB) purchases health benefits for employees of the State of Oregon. PEBB was created in 1999, joining the State Employees Benefits Board (SEBB) and the Bargaining Unit Benefit Board (BUBB). SEBB had purchased benefits for non-represented workers while BUBB had purchased for represented workers. PEBB was created to improve the buying power and sophistication of the state. Oregon's Department of Administrative Services administers PEBB, which is composed of three labor representatives, four state representatives and one representative who represents employees who are eligible for labor representation but are not otherwise represented. The administrator of the Office for Oregon Health Policy and Research is one of the state representatives.

The Department of Human Services through the Office of Medical Assistance Programs (OMAP)[*] purchases health benefits for SCHIP and Medicaid. Contracts are negotiated with OHP carriers based on rates set by an independent actuary. Fee for service rates are set by the state. Purchase of various services, especially prescription drugs, is regulated by federal and state statute. The Department of Human Services is responsible for all operational elements of the Medicaid plan while the Office for Oregon Health Policy and Research has oversight and policy roles for the Oregon Health Plan.

The Oregon Medical Insurance Pool (OMIP), the Family Health Insurance Assistance Program (FHIAP) and the Insurance Pool Governing Board (IPGB) are all administratively staffed by the same agency, with OMIP also a part of the Department of Consumer and Business Services. Administrative services related to these programs are either done in-house or contracted by bid. Health care services are provided through private carriers after an application or bidding process.

PEBB is Oregon's largest purchaser of health benefits. PEBB has been able to negotiate comprehensive health benefit plans for state employees that provide coverage with modest cost-sharing ($1,000 out of pocket). The state has subsidized HMO coverage in the past. The current Oregon market has caused significant changes in the most recent RFP/contract cycle. Premiums

[*] The 2001 Oregon Legislature authorized reorganization of the Department of Human Services (DHS). The new DHS Cluster includes these former separate agencies: Oregon Health Division, Office for Medical Assistance Programs, Alcohol and Drug Abuse Programs, and the mental health functions of Mental Health and Developmental Disability Services Division. This report will refer to agencies as they were prior to the reorganization. Additional information about the DHS reorganization can be found at *www.hr.state.or.us/dhrinfo/future/org-proposed.html*.

for PEBB will increase more than 20% in 2002, over $60 million. Only two plans will be available to most employees—Kaiser and a statewide PPO offered by Regence BlueCross BlueShield of Oregon. A major HMO providing PEBB coverage recently announced its departure from the HMO market. Maintaining current HMO carriers would have required a 50–60% premium increase. While some of this increase is due to rate guarantees negotiated by PEBB in previous years it is clear that even the state's largest purchaser is vulnerable to the current market turbulence.

Medicaid is a major purchaser of health care services in the state, particularly for those communities and providers who serve the Medicaid population. Many rural counties receive 40% of their provider revenue from Medicaid. Medicaid is the largest purchaser of prescription drugs in the state. Strategies that would have Medicaid jointly purchase with other state agencies have been considered, but are limited by statute and by potential complexity.

Health care services purchased by the Department of Consumer and Business Services are small in comparison to PEBB and Medicaid. FHIAP and OMIP are directed to provide a private insurance option to their participants and are therefore purchased based on private rates. There is no arrangement between PEBB, the Department of Human Services, or the Department of Consumer and Business Services in regards to joint purchase of any health care services.

Many other state agencies also purchase health services, such as the Department of Corrections, the Oregon Health Division, and the Oregon University System. The Department of Administrative Service assists in joint purchasing for these smaller agencies when possible, such as for prescription drugs. The services purchased by these agencies are very unique and do not yet represent a significant opportunity for linkage with the major state purchasers.

3.5 What impact would current market trends and the current regulatory environment have on various models for universal coverage? What changes would need to be made in current regulations?

Current market trends in Oregon show a contraction rather than an expansion of employer-sponsored insurance, especially for smaller firms and firms with a preponderance of low-wage employees. These trends include the following:

- Benefits are becoming less comprehensive, with dental and vision coverage and other "rider" benefits seen less frequently.
- Cost sharing is increasing, with a higher incidence of deductibles.
- Employer contributions to dependent coverage are decreasing.
- Fewer employers are offering dependent coverage.

This set of market trends will impact public and private programs in the OHP2 expansion in different ways. Regarding proposed subsidies for employer-sponsored insurance (ESI), there are two significant implications:

- The proposed ESI subsidy strategy will likely find strong demand where dependent coverage is still offered.

- The incidence of offering ESI for dependents, and the amount contributed toward premium cost by the employer, are dwindling over time. This argues for implementing the ESI program as soon as possible, and for publicizing the coming of the program well in advance of implementation.

The success of FHIAP and the prospect that funding may become available for many of the almost 20,000 Oregonians on FHIAP's waiting list may help to slow erosion of the offering of ESI to dependents of low-wage employees, and the amount contributed toward such coverage by employers.

Regarding the public expansion through "individual coverage" for non-categorical adults, OHP Standard, there are also two significant implications:

- Many dependents currently covered through ESI will become uninsured as employers stop offering dependent coverage. Dependent coverage could remain available but become unaffordable because of reduced employer contributions, increased total premium cost, or both.
- Reduction in the availability and affordability of ESI for dependents may cause some families currently on Medicaid to remain on Medicaid rather than risk being uninsured as the parents join the workforce.

The current regulatory environment in Oregon is not remarkable. Individual insurance is widely available, although underwriting is permitted. Oregon has not moved to a modified community rate, as several other states have in recent years. There is not guaranteed issue in the individual market, but there is recourse. Those who are denied individual insurance due to pre-existing conditions have the Oregon Medical Insurance Pool (OMIP) available to them, a high-risk insurance pool funded through premiums and a pro rata assessment on health insurers and reinsurers doing business in the state. The small group market is regulated as to rate variance, and there is guaranteed issue. There are benefit mandates to the group market (notably, mental health parity) and the individual market (notably, maternity care for all insured).

3.6 How would universal coverage affect the financial status of health plans and providers?

The Oregon marketplace for health plans and providers has been a turbulent one over the last decade.[*] A unique approach to Medicaid delivery has evolved in Oregon as a result of this turbulence—community-oriented, provider-dominated Medicaid-only HMOs that increasingly provide sole delivery systems for the Oregon Health Plan. The Access Subcommittee of the Oregon Health Council reported on these plans in the spring of 2000.[†] These community plans have continued to evolve.

The Oregon marketplace has been significantly affected by three strategies oriented to universal coverage: the original Oregon Health plan, the proposed Clinton Plan and resultant market

[*] For more information, see The Oregon Health Plan and Oregon's Health Care Market Place at *www.ohppr.org*.
[†] See "Recommendation on the Expansion of Access," Access Subcommittee of Oregon Health Council, October, 1996 at *www.ohppr.state.or.us/health/index_health.htm*.

reaction, and the reforms of the Oregon Health Plan over the last two years. While each strategy had ambitions for universal coverage, the net effects have been marked by incremental achievements and failures, often of significant proportions.

Major impacts on public markets by OHP included:

- Transition of Medicaid enrollees to managed care plans
- Substantial entry by private HMOs into the Medicaid market
- Innovative organization of Medicaid-only HMOs

By the late 1990s, almost 90% of Medicaid enrollees were in managed care plans. More than two-thirds of Medicaid enrollees were in private HMOs and the other third were in innovative Medicaid-only HMOs. Substantial improvements were documented in access, satisfaction and disease prevention benchmarks. By the mid-1990s profitability had increased across all provider sectors and most health plans. Cost shift decreased by 40–50%, enabling carriers to reduce and stabilize commercial premiums.

Major impacts on private markets occurred in the same time frame. Legislation creating a high-risk pool funded in part by insurer assessment, Oregon Medical Insurance Pool (OMIP) stabilized the individual insurance market leading to more predictable coverage and premiums. Legislation creating a small group basic benefit package and information about small group options also increased availability and predictability of premiums. The prospect of an employer mandate encouraged employers to take advantage of a limited tax credit program. Government focused on basic benefit approaches rather than mandates, reducing the real and perceived impact of mandates on the private market. Employers enjoyed the lowest premium increases in recent history. Commercial insurers enjoyed the most profitable years in their history.

This phase ended when it became clear that the employer mandate would not be implemented. Elimination of the employer mandate not only ended the major private portion of the Oregon Health Plan, but it made explicit that the Oregon Health Plan would be an incremental strategy rather than a comprehensive approach to universal coverage.

Oregon prepared for the Clinton Health Plan like many other states. Given the significant penetration of HMOs in commercial, Medicare, and now Medicaid markets, Oregon seemed to be an ideal market for the Clinton approaches. The Clinton Plan, and the reaction to it, further empowered the evolving managed care movement in the state. Oregon was an example of the ability of the "market," whether public or private, to affect reform with government participation rather than interference.

Oregon moved forward with initiatives in the late 1990s consistent with a market approach. The Family Health Insurance Assistance (FHIAP) program was created using state-only funds to subsidize low-income Oregonians for individual and employer-based insurance. Oregon actually eliminated some small group initiatives in the late 1990s because of the success of the small group market, notably the certified small group plans offered by the Insurance Pool Governing Board (IPGB).

Market reform, however, by definition creates winners and losers. Profit margins narrowed for both health plans and providers, competition increased, and given the profits of the mid-1990s, expectations increased. The late 1990s were marked by painful market adjustments. Large physician groups failed, particularly those pursuing physician practice management strategies. Many specialty physicians not sufficiently oriented to managed care left the market. Large hospital systems with dominant market shares used their clout in contracting to minimize, if not eliminate risk, while insisting on rate increases double the medical Consumer Price Index (CPI). Surviving physicians organized into Independent Practice Associations to increase their negotiating clout.

Medicare HMO rate increases failed to keep up with provider expectations. Health plans were tossed about within the turbulence of market reform and patient protection. Eventually health plans and providers returned to cost shifting and selection strategies to survive. Commercial HMOs began to withdraw from Medicaid markets, reduce Medicare enrollments and pass along provider increases to their commercial customers. Hospitals returned to cost shifting to meet their increased profit expectations. Physicians began to overtly select better paying and less sick populations in order to survive and compete. Some Oregon markets experienced greater than 50% turnover within their primary care infrastructure, leading to uncertainty and instability. This tumult demonstrated to policymakers that market reform would also be incremental and would require timely intervention and guidance in order to be sustained.

By the late 1990s, it was clear that a third set of strategies would be required for Oregon to weather these earlier efforts. Communities reacted by organizing community-oriented, provider-dominated delivery systems to care for Medicaid patients. In these communities:

- Participation by physicians and hospitals was almost universal
- Selection was minimized
- Communities were stabilized by improved information and the assurance that all resources for the community were staying in the community

These delivery systems provided a base to reform the public side of the Oregon Health Plan. Many of the surviving organizations were more innovative in their original design and included safety nets and other diverse providers. The safety net itself is becoming more organized.[*] Commercial HMOs have stabilized their Medicare and commercial plans for the moment, although with significant rate increases. Proposed OHP reforms will further stabilize the public marketplace, placing more emphasis on public/private partnerships for low-income workers. The nature and success of further public/private collaboration will be key to the success of incremental strategies to increase coverage.

Oregon has accepted incremental steps toward universal access emphasizing the importance of both public and private coverage. The state has learned the complexity of the health plan and provider marketplace needs careful and constant consideration. In retrospect, strategies that purport to achieve universal coverage can result in challenges as the political and business environment change, elements of those strategies fail leaving an incomplete approach.

[*] See "Role of the Health Care Safety Net" at *www.ohppr.org/hrsa/index_hrsa.htm*, under Briefing Papers.

Incremental strategies on the other hand, while easier to implement, have consequences far beyond what even the most knowledgeable strategist might anticipate.

3.7 How did the planning process take safety net providers into account?

A specific project goal for Oregon's HRSA State Planning Grant was devoted to improving the capacity and capability of Oregon's safety net clinics to provide care to uninsured Oregonians, including Hispanics and other immigrants, as well as homeless. It was hypothesized that linking safety net providers to improved data systems and information sharing would result in a safety net system that increases continuity of care.

In order to learn more about the safety net,[8] the HRSA Team participated in several efforts, including:

- Oregon's Committee on Health Care Safety Net Support, consisting of more than 100 safety net providers, advocates and government officials. Committee members identified the accomplishments and needs of Oregon's safety net and prepared a unified voice for the Oregon 2001 legislative assembly.[*]
- Tri-County Communities in Charge Project, whose goal is to implement a collaborative process designed to establish and implement a new system for delivering and financing high quality, affordable, culturally competent health care for medically uninsured and underserved populations of Multnomah, Washington and Clackamas Counties.[†]
- Participation in a Federal Financial Participation (FFP) work group, sponsored by Multnomah County, to review the financing behind health and social service programs in Oregon. The group identified four areas to capitalize on FFP opportunities and Multnomah County Commissioner approved the plan in August 2001.[9]

  These areas include:

  - Administrative cost claiming
  - Expanding the types of services reimbursed by Medicaid
  - Altering provider status
  - Alignment of reimbursement systems with integrated service delivery

Representatives from safety net clinics and advocacy groups provided input and feedback on a variety of ideas to support Oregon's safety net. The HRSA Team met with the Oregon Primary Care Association, Oregon Office of Rural Health, and Oregon Community Health Information Network to consider how the State could best support and compliment its current and future efforts. In addition, the HRSA Team gathered representatives from the safety net and advocacy communities along with government officials to explore CHIP Too and how to compensate safety net providers for services provided to those eligible for the OHP but not yet officially enrolled.

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[*] Please see *www.orpca.org* for more information.
[†] Please see *www.co.multnomah.or.us* for more information.

In addition, the HRSA Team, in partnership with the Health Services Commission and the Oregon Health Council, conducted 43 stakeholders meetings regarding benefit changes for insurance coverage expansion of the OHP (OHP2). Safety net providers, ethnic and culturally specific groups, and advocacy organizations were asked to provide their expertise and insights on health care benefits and cost-sharing trade-offs resulting from HB 2519.[*]

3.8 How would utilization change with universal coverage?

Oregon's two proposals for expansion, the OHP2 insurance coverage model and the CHIP Too "access" model are the next steps in Oregon's incremental approach.[†] Based on experience gained through implementation of the Oregon Health Plan Medicaid Demonstration in 1994 and examining the current health care market in Oregon, the following changes in utilization are expected:

- *Primary care utilization should increase,* as more adults and children are covered for preventive and primary care, including screenings and diagnostic tests. The benefit design for OHP Standard in the OHP2 model calls for little or no cost-sharing for preventive or primary care, as does the current OHP package, which will continue for the more vulnerable populations. In the private market, there has been some decline in HMO plans with minimal cost-sharing for primary and preventive services, so the expansion through private plans may show less of an increase in these two areas of service, depending upon the standards set in the basic benefit benchmark plan(s) by IPGB.

- *Emergency room (ER) utilization should decrease, especially ER utilization that does not result in a hospital admission.* This is expected because thousands of Oregonians who were previously uninsured will have access to physician office and clinic settings for non-emergent care. However, the original OHP "new eligibles" enrollees, who will now be on OHP Standard, will need to be monitored for a change in ER utilization. With increased cost-sharing, compared with their current OHP plan, it is critical to determine if increased cost-sharing becomes a barrier to seeking earlier and less-emergent care in out-patient settings.

- *Hospital care for preventable conditions should decrease.* Higher preventive and primary care utilization should result in diagnosis earlier in the disease process, which in turn should increase patient responsiveness to outpatient treatment before inpatient care is needed. Again, it is important to assess if the changes in cost-sharing for OHP Standard have an impact on hospital care for some current enrollees.

- *Specialty physician care in outpatient settings should increase and inpatient care should decrease as a result of earlier diagnosis.* More of the currently uninsured will now have access to specialty services that are currently unaffordable or not available through all safety net clinics.

[*] See Public Meeting Summary at *www.ohppr.org/hrsa/index_hrsa.htm*; under HSC/HRSA Public Outreach.
[†] The two approaches, OHP2 and Chip Too, are outlined in Section 4 of this report.

- *Dental preventive care should increase* as more adults and children have access to affordable care. This was seen with implementation of the original OHP Demonstration.

- *Outpatient mental health care should increase*. Individual OHP Standard coverage through Oregon Medical Assistance Programs (OMAP) will include mental health parity. Subsidized employer-sponsored coverage through FHIAP will include the mandated level of mental health outpatient care (10 visits per patient per year), although insurance carriers may offer higher levels of benefits, if they choose to.

- *Inpatient mental health care may decrease.* Although those with disabling mental illness will be covered through the current OHP package, OHP Plus (which includes mental health parity and comprehensive mental health benefits), some patients with chronic mental health conditions that are not disabling may be covered under a less rich benefit package through subsidy of employer-sponsored insurance through FHIAP.

With the CHIP Too "access" model, changes in utilization are also anticipated but the most notable impact of implementing CHIP Too is the effect it will have on the OHP2 insurance coverage model. More children and eventually more adults will have access to preventive and primary care services through the Safety Net prior to entering OHP2. This should lead to a healthier population entering OHP2, lowering the need for some health care services. This could improve the risk-related severity of disease in the OHP population.

3.9 Did you consider the experience of other State's with regard to:

Expansion of public coverage?
Public/private partnership?
Incentives for employers to offer coverage?
Regulation of the marketplace?

Expansion of public coverage:

Oregon's HRSA Team examined several states' approaches to public coverage. As part of the work with the Health Services Commission and developing the benefit structure, the Team researched the other states that had expanded their public coverage by defining a basic benefit plan. While we looked at many states, there was extensive review of the following:

- Massachusetts' Basic MassHealth
- Washington State's Basic Health Plan
- New York's Family Health Plus and "Healthy New York"
- Minnesota's MinnesotaCare
- Wisconsin's BadgerCare

With all five, the Team looked at the benefit package design, cost-sharing features and implementation approaches. Some of the outcomes of these expansion programs, such as the

utilization studies of Washington's Basic Health plan and current concerns facing the Massachusetts and Minnesota systems as health care costs are rising were also explored.

Public/private partnership:

Besides looking back at Oregon's previous attempts at bringing the public and private insurance worlds together, the HRSA Team researched more recent attempts of the following states:

- New York's "Healthy New York" program
- Massachusetts' MassHealth Family Assistance premium assistance and "buy-in" program
- Wisconsin's BadgerCare partnering with private insurance
- Tennessee's new reform proposal developed by the Commission on the Future of TennCare
- Rhode Island's RIte Care and RIte Share Programs

The HRSA Team looked at the benefit package design, cost-sharing features and implementation approaches. Some of these are very recent, so less outcome information is available. The new reforms for TennCare resemble Oregon's proposed insurance coverage approach, and the HRSA Team will monitor its progress through Spring 2002.

Despite the success of the Oregon Health Plan and passage of HB2519, access to health care remains an issue for the approximately 380,000 Oregonians who will remain uninsured. Communities across the country have been examining the ways that they provide care for the uninsured, and other vulnerable populations. The HRSA Team looked at several community-based initiatives in order to consider the best practices of caring for Oregonians who are at risk of "falling through the cracks." [10], [11], [12]

- Suburban Primary Care Health Council in Westchester, Illinois and their Access to Care® program, a successful example of caring for the uninsured within a community with a broad participation by providers and serving over 50,000 individuals since first started in 1988.*
- Alameda County, California convened the Access to Care Collaborative to oversee the Robert Wood Johnson Foundation-funded Communities in Charge project, The W.K. Kellogg Foundation-funded Community Voices project, and generally to increase health care coverage and access to high quality care in the county. As part of these efforts, the Alameda Alliance for Health, the local, not-for-profit HMO, allocated $14.87 million of their reserve funds to offer Family Care, a subsidized coverage product for uninsured residents up to 300% of the FPL, including undocumented immigrants.
- Hillsborough County, Florida and their Hillsborough County HealthCare Plan that offers comprehensive managed care with five different benefit packages to the uninsured at or below 100% of the FPL. By contracting with providers in the

* Please see *www.sphcc.org* for more information.

community, enrollees are "mainstreamed" and given access to the same providers as others with conventional insurance coverage.[*]

- Muskegon, Michigan and their small business buy-in model, Access Health. This health coverage benefit program is available to individuals through their employer. The program is financed through a three-way shared buy-in in which employers, employees and the community each cover a portion of the cost. The employer and employee each pay 30% of the cost with the remaining 40% covered by the community. The community match portion of Access Health is a combination of federal, state and local funds. The program is structured so that every $1 of public money is leveraged by $2 of private money.[†]

These are just a few of the successful examples of community-driven approaches to expand coverage to the uninsured. The HRSA Team analyzed unique public and private partnerships that have allowed access to primary care, and in some cases ancillary pharmacy, dental, laboratory, and radiology services. These cooperative efforts have allowed enrollees to access hospital care and other secondary and tertiary providers in some of these communities. Public/private partnerships frequently integrate the best of managed care principles into a community-based model in order to deliver quality health care to the uninsured.

Incentives for employers to offer:

Attending the State Coverage Initiatives Program on Small Group and Individual Health Insurance Markets in Seattle, April 2001 allowed Oregon to learn first-hand from several western states about attempts to assist the small and individual health care market and their experience. Participants included California, Colorado, Idaho, Minnesota, North Dakota, Texas and Washington.

Oregon also looked in more detail at several other states and specific programs:

- New York's "Corridor Stop Loss" subsidy program in the "Healthy NY" program, using re-insurance subsidy.
- Washington State's attempts at getting the Basic Health Plan into the employer-sponsored market, and the impact of the erosion of the individual market in Washington.
- Colorado's employer buy-in feasibility study which suggested using CHIP dollars and enrolling kids in ESI would not be cost effective. They found it might be effective if parents are included via a Medicaid expansion.
- Massachusetts' employee-subsidy and their employer-subsidy programs. Oregon examined their thinking on crowd-out, stabilizing the small group market, and combining Title XIX and Title XXI funds.
- Wisconsin's HIPP program, especially concerned with their low enrollment.

[*] Please see *www.hillsboroughcounty.org* for more information.
[†] Please see *www.mchp.org* for more information.

- Rhode Island's RIte Share (Premium Assistance) program's design of enhanced benefits compared to the commercial market and crowd-out.

Regulation of the marketplace:

Oregon's HRSA Team looked at a variety of states in terms of mandated benefits and regulations impacting the marketplace:

- Minnesota had done an extensive review of state-mandated benefits and their impact on benefit design, especially among self-insured firms. This review was quite valuable and would be a useful research project to further analyze our Oregon marketplace.
- Rhode Island has been attempting to control crowd out by stabilizing the cost of employer-sponsored insurance for small business and assisting low-wage workers to obtain and/or maintain employer-sponsored health insurance. These are critical issues as Oregon looks to implement HB2519.
- Colorado's Small Groups and Rural Access Task Force was studied to see how the state is developing strategies to improve the viability of the small group market in the areas of the state where erosion of companies has occurred, as has occurred in Oregon.

Beyond individual states' efforts, the HRSA Team also looked at several groups' efforts at universal coverage. Several members of the Grant Team attended the "Strange Bedfellows" initiative presentation in Seattle, which incorporated a collaborative effort by several distinctly different groups. The HRSA Team also extensively reviewed the recent proposal by the American Academy of Family Practice for Universal Healthcare Coverage. It was examined in terms of its unique approach to defining basic benefits, as well as its overall financing structure that would merge multiple funding streams, public and private together.[*]

[*] See "AAFP Draft Proposal: Comments from the Oregon HRSA Team" at *www.ohppr.org/hrsa/index_hrsa.htm* under HRSA Initiated Documents.

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Section 4

Options for Expanding Coverage

4.1 What coverage expansion options were selected by the state (e.g. family coverage through CHIP, 1115 Medicaid waivers, 1931 Medicaid, ESI, tax credits for employers or individuals, etc)?

Oregon has decided to pursue coverage expansion options using two waiver approaches. The first waiver approach, an insurance coverage model, is referred to as OHP2, while the second, an access model, is referred to as CHIP Too.[*] The selected coverage options include:

- Family choice of coverage, through a combined CHIP/Medicaid 1115 waiver;
- Expansion of employer-sponsored insurance (ESI) through the Family Health Insurance Assistance Program (FHIAP), currently funded only with state funds;
- Implementation of a new Medicaid benefits package for adults from 100–185% of the Federal Poverty Level (FPL);
- Direct payment to safety net providers for care received by children presumably eligible for CHIP but for whom the application process has not been completed, hereafter referred to as simplified eligibility.

In the future Oregon may test the feasibility of tax credits for employees or refundable tax credits for individuals. Tax credits for employers were a part of the Small Employer Health Insurance program implemented in Oregon in 1989. Tax credits, declining over time, were offered to small employers who had not offered health insurance to employees for at least one year. The program enrolled thousands of small business employers, but evaluation of the program indicated that its success was due more to effective marketing than to the tax credits offered.

The 2001 Oregon Legislature passed House Bill 2519, authorizing Oregon to pursue OHP2, which, if approved, will allow coverage for more than 50,000 additional Oregonians. A major policy objective of OHP2 will be to test various mechanisms for permitting families to select the appropriate combination of health coverage programs from among available options, including both private and publicly sponsored insurance in many cases. As long as all available coverage programs qualify for federal financial participation and subsidies are appropriate to family income in all available coverage programs, the fiscal impact of the coverage choices made by participating families will be buffered for both government and the families themselves.

The implications of differences among available coverage programs in benefits and cost sharing will be substantial for many families. This means that effective choice counseling will be required to assure informed choice, and opportunities to opt into and out of the various options

[*] In subsequent subsections there will separate responses for OHP2 and CHIP Too as appropriate.

must be carefully designed to mitigate inadequate access on the one hand and adverse selection on the other.

OHP2 would create two different benefit packages, OHP Plus and OHP Standard. OHP Plus would be provided to all aged, blind, disabled, and pregnant women as well as all children up to 185% of the FPL. OHP Standard would be provided, up to a capped enrollment, for adults from 100–185% of the FPL. OHP2 would also create benchmark health plans on the private commercial side, allowing for federal match for OHP eligible adults who access coverage through FHIAP.

CHIP Too,[*] an 1115 waiver application presently under CMS review, proposes a direct payment program using SCHIP funds for care received by children presumed eligible for SCHIP but for whom their parents have not completed the application process. The waiver would allow Oregon to use $5 million of its annual SCHIP allocation to directly fund primary health care and preventive services to these uninsured children accessing care at qualified safety net clinics.

Although "coverage" or insurance is the most frequent method to access health care services, not all people are willing, wanting, or able to be insured. The Oregon Health Council, principal health care advisory committee to the Governor, and the Office for Oregon Health Policy and Research, passed a resolution in Spring 2001, indicating that even the most committed efforts to achieve universal coverage will leave at least 5% of Oregonians without health insurance.[†] With that in mind, CHIP Too was designed to complement OHP2, to provide primary care with an emphasis on prevention to Oregon's uninsured children. CHIP Too would create community and population based delivery systems, encourage private and public partnerships, cost and risk sharing, and foster the idea that communities working together can create quality and affordable health care for all Oregonians.

CHIP Too would provide a "bridge" between coverage for health care and access to health care. By providing care to those not yet enrolled in OHP2, Oregon reduces the eventual risk to insurers as children enter the coverage model. Safety net providers will actively encourage and assist children and their parents to enroll in an insurance plan. The State provides catastrophic insurance, through retroactive eligibility, without providing coverage for primary care and preventive services.

4.2 What is the target eligibility group under expansion?

The target eligibility group for OHP2 expansion, the insurance coverage model, includes the following populations:

- Children with incomes from 170–185% of the FPL; children with incomes up to 170% of the FPL are already covered under the OHP, either through Medicaid, CHIP or FHIAP.

[*] "Chip Too: A strategy for expanding access to more uninsured children, June 2001": can found at *www.ohppr.state.or.us*.
[†] See "Safety Net Resolution," Salem, OR: Oregon Health Council; March 2001. *www.ohppr.state.or.us*.

- Pregnant women with incomes from 170–185% of the FPL; pregnant women with incomes up to 170% FPL are already covered under the OHP through Medicaid.
- Adults with incomes from 100–185% of the FPL; adults to 100% of the FPL are already covered under the OHP through Medicaid.

The number of uninsured Oregonians that will be covered through the OHP2 expansion will be limited (capped) to reflect funding limitation. Current estimates are that the OHP2 expansion will enroll approximately 40,000 in Medicaid and FHIAP and approximately 10,000 in CHIP.

All parents with incomes up to the TANF limit (approximately 60% of the FPL) will also be offered the OHP Plus benefits. Childless adults with income from 0–185% of the FPL, and parents with incomes above the TANF limit but below 185% FPL, will be offered the OHP Standard benefits.

The target eligibility group for CHIP Too expansion is children up to age 19 whose family incomes are at or below 185% of the FPL who are not covered by any insurance program, including OHP2. The proposed CHIP Too program will help meet the primary health care needs of Oregon's uninsured children and increase their enrollment into OHP2.

Despite Oregon's effort to insure children through OHP and SCHIP there are approximately 50,000 children who are uninsured and yet are potentially eligible for a publicly funded health insurance program. Due to racial, cultural and linguistic differences, lack of provider access, complex enrollment procedures, the stigma of governmental assistance and other complex reasons some parents cannot or will not enroll their children. An estimated 8% of Oregon's children are uninsured. Oregon and national data indicate that a significantly higher percentage of Oregon children have episodes of uninsurance within a year. CHIP Too will offer the support, education, and time that many families need to see the importance of continuous insurance coverage.

In addition to the eligible but not yet enrolled, there are many Oregonians, including children, who are covered by public insurance for several months but then become ineligible due to an increase in family income. A recent study indicated that 43% of people covered by the OHP leave within a year. More than 70% of those who disenrolled from the OHP were uninsured while off OHP.

4.3 How will the program be administered?

OHP2, the insurance coverage model, will be administered as a single program with two discrete operational arms. The Department of Human Services, using a process similar to how the Office of Medical Assistance Programs (OMAP) currently enrolls individuals through an eligibility process, will administer the first arm.[*] If eligible, individuals will be enrolled in the appropriate

[*] The 2001 Oregon Legislature authorized reorganization of the Department of Human Services (DHS). The new DHS Cluster includes these former separate agencies: Oregon Health Division, Office for Medical Assistance Programs, Alcohol and Drug Abuse Programs, and the mental health functions of Mental Health and Developmental Disability Services Division. This report will refer to agencies as they were prior to the reorganization. Additional information about the DHS reorganization can be found at *www.hr.state.or.us/dhrinfo/future/org-proposed.html*.

benefit plan—OHP Plus for the categorically eligible, children, pregnant women, TANF and general assistance, OHP Standard for adults and couples eligible based on income.

In areas served by managed care plans, enrollees will be enrolled in those plans. Information regarding benefits and administrative issues will be provided to enrollees as is done currently. OHP plans will then administer benefits for the population enrolled following all the current administrative guidelines. In areas without managed care providers will be reimbursed on a fee for service basis. If premiums are necessary collection of these premiums and ongoing eligibility will be administered by OMAP.

The second operational arm will be similar to the current Family Health Insurance Assistance Program (FHIAP). Individuals identified as having access to employer-sponsored insurance (ESI) will be referred to FHIAP. If the group coverage meets or exceeds benchmark benefit levels, contribution and cost effectiveness requirements these individuals will be enrolled in "group FHIAP" and receive coverage through their employer's carrier. FHIAP will administer the subsidy needed for purchase directly with the individual employee and not through the employer. FHIAP has demonstrated that this process is more efficient and acceptable to employers. FHIAP provides ongoing subsidies after the first month based on demonstration of employer coverage by the employee. The employer carrier will perform subsequent eligibility, claims and related issues.

Oregon is evaluating under what circumstances FHIAP will subsidize individual insurance. Current FHIAP members with individual coverage will continue though addition of individual insurance covered lives will be put on hold until a variety of issues regarding underwriting and selection are negotiated with private carriers. These individuals will have access to coverage through the first arm described—traditional Medicaid. Low income individuals rejected for individual coverage by private carriers will continue to have access to the Oregon Medical Insurance Pool (OMIP), the state's high risk pool, but will not have subsidies available until "individual" FHIAP is open.

The circumstances above arise because of the shared funding arrangement in the high risk pool. OMIP is funded by enrollee premiums and an insurer assessment based on total state market share. Public subsidies of low-income individuals for individual insurance result in subsidized high-risk individuals entering OMIP, thereby causing insurer assessments to rise. Insurer assessments are already rising because of recent increases in rejection rates by several insurers. Further study and negotiation will be needed to determine the best strategy for stabilizing the individual market and OMIP. Until then the first two arms described will be the focus of expansion.

The Department of Human Services (DHS) and the Office for Oregon Health Policy and Research (OHPR) will jointly manage CHIP Too, the access model. The DHS will be responsible for day-to-day administration including policy and program development, continuous quality improvement, and claims payment. The OHPR will be responsible for all data received from participating safety nets and prepare reports and evaluations. The DHS and the OHPR will maintain joint responsibility for assuring that CHIP Too complements the OHP2 coverage model.

The CHIP Too approach encourages local communities to provide a portion of the State's funding. As a result Counties, School Districts and potentially other community organizations might be involved in the funding and the administration of the program. An advisory committee works on administrative functions related to CHIP Too and other safety net efforts. The committee consists of representatives from Federally Qualified Health Centers (FQHC), Rural Health Clinics, School-Based Health Centers, free standing clinics, Oregon Community Health Information Network (OCHIN), CareOregon, the Oregon Primary Care Association, the Health Services Cluster, and OHPPR. After approval of the CHIP Too waiver request, the advisory committee will monitor the program's progress and make recommendations on how to improve the program.

4.4 How will outreach & enrollment be conducted?

OHP2 (Insurance Coverage Model)

The specifics of outreach and enrollment have not yet been determined in regard to OHP2, primarily due to recent OHP legislative changes and reorganization of the Department of Human Services (DHS). The goal of Oregon's DHS reorganization is creation of a better, more innovative system that will result in better services to clients. This will also create a more integrated and simpler process for recipients of physical, mental and public health programs, including OHP2. Currently, OHP and SCHIP have a single application and eligibility determination process. All applicants are screened for eligibility through the OHP application. A mail-in application eliminates the need for face-to-face interviews. However, Oregonians applying for the OHP in addition to other public assistance programs are required to have a face-to-face interview at a DHS branch office. OHP/SCHIP applicants are required to provide the following:

- Three-month proof of income
- Proof of citizen status
- If pregnant, proof of pregnancy and estimated due date signed by a medical provider
- If any family member has health insurance, health insurance cards
- If American Indian/Alaska Native, proof of status
- If a student, a copy of a Student Aid Report that shows Estimated Family Contribution and Pell eligibility status

Depending upon the qualifying level of income and categorical eligibility, the applicant is enrolled in OHP or SCHIP. Every six months enrollees need to re-apply. The specifics on the OHP2 enrollment process are yet to be determined but are likely to be similar to the current OHP procedures.

Despite simplification efforts, barriers to OHP enrollment still exist.[1] A study done by the Center for Outcomes Research and Education looked at those who lost their eligibility in the OHP.[2] Sixteen percent (16 %) of those who lost their eligibility said they did so because of paperwork issues. Of this group:

- Forty-eight percent (48%) said they forgot or didn't bother with the paperwork;
- Twenty percent (20%) said they submitted incomplete or incorrect paperwork; and

- Nine percent (9%) said the paperwork was too complicated.

Oregon's health advocacy community is working together to improve public insurance enrollment and outreach efforts. The Robert Wood Johnson Foundation Covering Kids Project, Expanded Access Coalition, Healthy Communities, Children First, the Oregon Primary Care Association, the Oregon Health Action Campaign, and others analyzed Oregon's outreach and enrollment procedures and created recommendations to address OHP barriers.[*] Suggestions to improve OHP enrollment and outreach efforts include:

- Launch a broad-based outreach and enrollment effort using culturally specific consumer tested marketing materials, informed by social marketing principles. The end result of a social marketing plan is that it becomes a "social norm" to have health coverage;
- Organizations working with low income Oregonians should have Oregon Health Plan applications and a date stamp available;
- OHP enrollees should have an insurance card with the dates of eligibility on it, not a sheet of paper;
- Parents who have past dues premiums should receive information in monthly premium bills indicating that children are still eligible;
- Payment plans should be made available for people who have fallen behind on their premiums. Currently, families who fall behind on premium payments and are terminated for that reason, have no option to pay the balance except with a lump sum payment;
- Expedite the eligibility determination process including the response to OHP applicants.

Presently, eligibility and enrollment assistance for the OHP and SCHIP are available at DHS's Adult and Family Services (AFS) and Senior and Disabled Services (SDSD) offices located throughout the state. Additionally, the Office of Medical Assistance Programs (OMAP) has 140 outreach facilities, which contract with OMAP to help people apply for public insurance programs. Oregonians can apply and enroll in the OHP and SCHIP at an outreach facility. Presently, there are contracted outreach facilities at places such as:

- Hospitals
- County health departments
- Federally qualified health centers
- Rural health clinics
- Migrant health clinics
- Family planning clinics
- Indian and tribal health clinics
- Alcohol and drug rehabilitation centers
- Alcohol and drug youth residential treatment centers

[*] See "Barriers to Access and Utilization" at *www.ohppr.org/hrsa/index_hrsa.htm*.

Other not-for-profit organizations devote employee time, administrative support, and other resources to recruit and retain OHP clients, but are not OMAP contracted outreach facilities. These agencies provide OHP enrollment services but do not have the official "date stamp" which formally begins the eligibility review of an OHP application. They are not always updated on changes to public insurance programs nor are they assured access to current marketing materials, e.g., posters and brochures. Furthermore, these unofficial outreach sites are not compensated for the OHP assistance they provide.

OHP2 will likely adopt aspects of the Family Health Insurance Program's (FHIAP) marketing strategies. FHIAP has proficiency working with insurance agents, small businesses, and low-income individuals with employer based coverage. In 1998, FHIAP partnered with private sector groups and organizations to roll out their program that subsidizes health-insurance premiums for low-income families. FHIAP facilitated a grassroots, community-based effort to reach the uninsured who were not eligible for the OHP and SCHIP.[3]

Some of FHIAP's partners include:

- Insurance agents
- Local community action programs
- Governmental public assistance programs
- Employment departments
- County health departments
- Safety net and rural health clinics
- Agricultural and industry associations
- Schools

FHIAP conducted eighty trainings throughout the state for their partners. Eighteen hundred (1800) people attended three-hour trainings on OHP, SCHIP, the Insurance Pool Governing Board (IPGB), and FHIAP. Continuing education credits were available for insurance agents. At present, due to state funding limitations and a 20,000-person reservation list for FHIAP, further outreach and marketing efforts are limited. Because of the new OHP2, Oregon is expected to revisit outreach strategies to low-income employees with employer-based coverage.[*]

CHIP Too (Access Model)

In order to help ensure that more Oregonians are educated about and enrolled in health insurance plans, a key component of CHIP Too, the access model, is to encourage public insurance options. CHIP Too will encourage enrollment in available coverage options.

The specifics of outreach and eligibility for CHIP Too are not determined yet, although a variety of outreach strategies are used by safety net clinics to make communities aware of services, including the opportunity to enroll in public insurance programs. CHIP Too is designed to encourage enrollment of eligible children into OHP2, therefore emphasis will be on outreach for OHP2 coverage not CHIP Too.

[*] See FHIAP July 2001 program brief section at *www.ipgb.state.or.us/Docs/fhiapgen.htm.*

CHIP Too will allow children accessing care at safety net clinics and seemingly eligible for OHP2 to be assumed eligible while their parents complete the formal enrollment process. To minimize administrative burden, CHIP Too applicants will complete a simple self-declaration form. Eligibility will be determined immediately at a participating safety net clinic. This eligibility process will be similar to that used by Oregon's Family Planning Expansion Program which provides family planning services to individuals up to 185% of the FPL, using a simplified eligibility process and claims form.[*] A work group consisting of diverse stakeholders will determine the specifics of the enrollment process.

4.5 What will the enrollee (and/or employer) premium-sharing requirements be?

Enrollee premium sharing for OHP2, the insurance coverage model:

- OHP Plus (renamed from the current OHP) has premium sharing for those under 100% of the FPL. Premiums will stay between $6 and $23 per month for each household. The amount of the premium share is based on gross income and family size, but no premium share is collected from children or pregnant women.
- Those on OHP Standard with incomes from 100–185% of the FPL will be charged a premium share based on a sliding scale related to their income level. The amount will exceed the current maximum of $23 a month, but depends on the cost of the OHP Standard and any actuarial equivalent benchmark plans.

Alternatively, persons with incomes up to 185% of the FPL who have access to employer-sponsored insurance will be eligible for premium subsidies for an approved plan through their employer. Building upon FHIAP's present subsidy levels, the proposed subsidies assumed for the initial pricing of OHP2 are:

- Ninety-five percent (95%) of the premium cost for incomes from 100–125% of the FPL;
- Ninety percent (90%) of the premium cost for incomes from 125–150% of the FPL;
- Seventy percent (70%) of the premium cost for incomes from 150–170% of the FPL;
- Fifty percent (50%) of the premium cost for incomes from 170–185% of the FPL.

The proposed subsidies may be adjusted as waiver design and implementation plans are refined.

In the FHIAP Study, when respondents were given a choice of reducing the number enrolled in FHIAP or reducing the subsidy, 70% chose "Reduce the Subsidy". However, about 40% said they could not afford any reduction in their subsidy, and 33% could only afford a 5% decrease.[†]

FHIAP's original subsidy levels were derived from looking at affordability, as well as the average market premiums for standard HMO and PPO products in the individual and group markets. Originally, it was decided not to include caps on the amount of subsidy because of differences between the individual, OMIP, and group markets. Without caps on the subsidy, all

[*] For more information, see *www.ohd.hr.state.or.us*.
[†] See "FHIAP Leavers Survey" and "FHIAP Survey of Enrollees and Individusals on Reservation List: Summary Report" at *www.ohppr.org/hrsa/index_hrsa.htm*.

age groups are treated the same in terms of premium costs, and all insurance markets are treated without favor. It was felt that at the original subsidy levels, selection of a plan with comprehensive benefits and low deductibles was encouraged.*

HB 2519, passed by the 2001 Oregon Legislature, does not outline specific subsidy levels; only that OHP2:

> *shall provide public subsidies for the purchase of health insurance coverage provided by public programs or private insurance.*

The Health Services Commission will recommend premium levels for the *public-side* of OHP Standard coverage. The Insurance Pool Governing Board, in consultation with the Health Insurance Reform Advisory Committee, will identify and recommend a basic benchmark health benefit plan(s) that qualify for subsidy on the *private* side. The exact subsidy amounts have not yet been determined. HB 2519 states that:

> *public subsidies shall apply only to the cost of the basic benchmark health benefit plan or the approved equivalent…*

Additional cost sharing in the form of co-pay, co-insurance or deductibles will be allowed under HB 2519 legislation in the public OHP Standard, and are already in most private market health plans.

There are still some issues to be worked out for enrollees. In the current OHP, premium shares are not charged to:

- Pregnant enrollees
- Enrollees under age 19
- Enrollee in long-term care facilities
- Enrollees of American Indian/Alaska Native heritage

The first three groups will be on OHP Plus, so this remains unchanged from the current enrollment. However, enrollees of American Indian/Alaska Native heritage could be eligible for either OHP Plus or OHP Standard, depending on their individual situation. Since tribal members are not currently charged premiums under Medicaid because of federal tribal agreements, it will require further discussion in the waiver implementation phase to clarify how proposed changes will impact this population on both on the public and private portions of OHP2.

In the current OHP, there is a process for premium shares to be waived or forgiven under certain specific situations. These situations include:

- Enrollee has been a victim of domestic violence
- Enrollee has been a victim of crime that caused the loss of income or resources
- Enrollee has lost their housing, forcing them to move
- Enrollee is homeless

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* Insurance Governing Board Family Health Insurance Assistance Program brief of December 2000 (Revised 1/3/2001) at *www.ipgb.state.or.us/Docs/fhiaphome.htm*.

- Enrollee has no income

These circumstances will need to be re-examined to determine if these enrollees will be responsible for premium share if they qualify for OHP Standard, since the budget assumes everyone will pay on a monthly basis, or else lose eligibility a month later. In some communities, poor and low-income individuals have premiums subsidized or "financed" by third parties. The HRSA Team intends to study these arrangements in a large safety net operation that has had success with this strategy.

Employer premium sharing for OHP2, the insurance coverage model:

Oregon law mandates a minimum employer contribution towards employee coverage of 50%. Currently, the FHIAP program accepts whatever contribution an employer is willing to provide towards the family premium and in many instances, the employer contribution is only for the employee, with no coverage offered by the employer for dependents. To participate in FHIAP, adults are eligible for the subsidy only if all eligible children are covered by a health benefit plan or OHP/CHIP.

The amount of employer contribution expected under OHP2 is not yet determined. Nationally, the Center for Medicare and Medicaid Services (CMS) has approved a 50% contribution in Massachusetts and Wisconsin in expansions through employer-sponsored insurance. This is down from 60% on employer contribution that has been required in past waiver requests. If an 80–90% employer contribution is spread over a family of four, it might result in something close to a 50% premium contribution to the entire family, depending on the premium costs.

The HRSA Team is using employer interviews to determine what the actual average contribution is in Oregon. IPGB surveyed the state's major carriers who offer to employers with 50 or fewer employees to determine their level of contribution. The HRSA Team hopes to determine what employers of the working low-income uninsured contribute to their employees' insurance. It appears that smaller employer and employers with predominately low-income workers are more likely to have lower contribution rates. Higher levels of employer contribution would be expected in more moderate to high-income populations. The employer contribution expected in OHP2 should match what is common for those employers currently offering insurance to the target population.

Enrollee premium sharing for CHIP Too, the Access Model:

CHIP Too will not require monthly premiums like the OHP2, although some safety net clinics already serve patients who contribute to the cost of their health care through monthly payments. Safety net clinics providing services under CHIP Too will be required to have a sliding fee scale, however, no one will be denied services if they are unable to make such a contribution. Furthermore, some clinics as well as communities subsidize premiums for low-income patients.

Two thirds of Oregon's uninsured are either employed by small companies or are the dependents of those employees. Many of these small businesses do not offer health insurance. Employees often cannot afford the premiums to participate in a traditional coverage option, especially for their dependents. If CHIP Too proves to be a viable and successful coverage alternative, a future

step may be to offer a buy-in option for small businesses. One example is *Access Health* in Muskegon, Michigan, a health coverage benefit program available to individuals through their employer. Businesses are eligible to participate if they are located in Muskegon County, have a median wage of $10 an hour or less and, have not offered health insurance for the previous 12 months. The program is available to full and part-time employees and dependents who do not have other health insurance coverage. The program is financed through a three-way shared buy-in in which employers, employees and the community each cover a portion of the cost. Families with eligible children are encouraged to enroll in SCHIP. The community match portion of Access Health is a combination of federal, state and local funds. The program is structured so that every $1 of public money is leveraged by $2 of private money.

4.6 What will the benefits structure be (including co-payments and other cost sharing)?

OHP2 (Insurance Coverage Model)

Initially, the actuarial work on the benefit structure, sponsored by the HRSA Grant, began with comparisons to the current OHP package at 100%. Comparisons were made with the minimal federal Medicaid mandates, Medicare, and several commercial products offered in Oregon. This allowed the Health Services Commission to see how benefits varied and their cost. The actuary worked through a process of reducing the benefits with cost sharing, working down from the 100% current OHP package towards a reduced package with an actuarial value of about 20% less. The actuary used a computer model to apply the various cost-sharing strategies to see their impact on the overall actuarial value. As HB 2519 evolved during the legislative session, the process was reversed. It was decided to start from the federal Medicaid mandates at 57% of the current OHP package, and build up. The resulting design is outlined in HB 2519.[*] To summarize:

Public-side OHP Standard:

- This shall be the combination of the basic benefit package actuarially equivalent to the federal Medicaid mandates of the Social Security Act, with additional benefit packages added in priority order by the Health Services Commission.
- The initial benefit package will be the minimum level of care mandated by the current federal Medicaid law. Fifty-seven percent (57%) actuarial value as compared with the current OHP plan.)
- Additional packages will be also be developed, with the Health Services Commission asked to rank them in benefit priority order so that the Legislature can determine the level of funding available for the additional benefit packages.
- The Health Services Commission will recommend cost sharing for OHP Standard.
- Cost sharing cannot exceed the cost of OHP Plus (the current OHP package).
- Cost sharing will be based on an individual's ability to pay, and HB 2519 states that copayments and premiums will be structured "*in a manner that encourages the use of preventive services.*"

[*] See HB 2519 available at *pub.das.state.or.us/LEG_BILLS/PDFs/EHB2519.pdf.*

Public-side OHP Plus:

- The Health Services Commission will continue to prioritize the list of health care services, using it to establish the OHP Plus benefit package of health care services.
- The 2001–2003 Biennium budget for the OHP did initiate some minimal cost sharing in the form of copays on medications that will apply to all OHP Plus enrollees. The copays will be $2 for generic drugs and $3 for brand-name drugs. There will also be $5 copays for some enrollees on certain outpatient services.
- Pregnant women and their newborns will be covered with the OHP Plus benefit package, expanding coverage from 170–185% of the FPL.
- Children under age 19 will continue to receive OHP Plus, with coverage expanded to include those from 170–185% of the FPL in the CHIP program.

The Health Services Commission held lengthy discussions during the past year regarding basic benefit and cost sharing issues, as they reviewed the actuarial comparison of plans and analyzed individual benefit costs. The Commission debated exclusions and limitations in relation to specific services (i.e. diagnostic services, vision services, dental services, durable medical equipment, medical supplies, and non-emergent transportation) as well as how to apply cost sharing.

The Health Services Commission has been considering:

- Copays for emergency room services when not admitted,
- Cost-sharing options for prescription drugs,
- Additional gradations in coinsurance according to income level,
- Deductibles for certain services, while not creating barriers to preventive care,
- Sliding scales for out-of-pocket maximums based on income limitations to avoid barriers to care.

The Commission held a series of public town hall and stakeholder meetings to discuss the challenging decisions to gain public input. The meetings were conducted in July and August 2001 in preparation for decisions scheduled for early September. The HRSA team was involved in developing the content and format of the public meetings.[*] The public was asked to recommend tradeoffs on types of benefits and cost sharing approaches. Efforts were made to maximize low-income uninsured participants at the public meetings.

The Health Services Commission met on September 26, 2001 and did not make final decisions on benefit choices and their prioritized ranking of the various packages. The Commission will meet in early October. The benefit plan will then be submitted to the interim legislative committee with oversight of health care issues, the chairpersons of the Emergency Board (which meets between legislative sessions) and the Waiver Application Steering Committee (as outlined in HB 2519) for approval and incorporation into the waiver to CMS.

[*] For a summary report of the public meetings, see *www.ohppr.state.or.us*.

The Health Services Commissioners feel strongly about maintaining a preventive focus in any benefit package. As they design the options of OHP Standard, they are attempting to balance the introduction of cost sharing without creating barriers to accessing care. Mental health parity and preventive dental services have been innovative features to the current OHP plan, and the Commission still strives to design affordable packages that include these benefits.

Private-side basic benefit benchmark plan(s):

- A waiver will be sought for the establishment of a basic benchmark health plan, or approved equivalent plans, for subsidized employer-sponsored coverage. HB 2519 states that the coverage be comparable to coverage commonly offered in the small employer health insurance market.
- The aim is for parents to have a choice of deciding if their children will be covered under the employer-sponsored coverage or through the public OHP Plus plan.
- Preventive services and access in the selected subsidized plans needs to be considered, especially as it applies to children's coverage.
- The Insurance Pool Governing Board (IPGB), which oversees FHIAP, will consult with the Health Insurance Reform Advisory committee (HIRAC) as designated in HB 2519. IPGB will recommend a basic benchmark health benefit plan(s) that will qualify for subsidy, taking into account employer-sponsored health benefit plans currently in the market.

To determine the private-side benchmark plan(s) that will qualify for subsidy, IPGB is examining the current insurance products offered in Oregon. The first step has been completed as the IPGB reviewed the prevailing plans offered in Oregon, identified by carriers as their most common benefit packages for employee groups 50 and under. IPGB is hoping to set the benefit benchmark broad enough to include the majority of the employer-sponsored insurance offered for the target population while still ensuring that it is adequate coverage.[*]

The HRSA Team will analyze the private-side benchmark work from an actuarial perspective similar to the public-side work done by the Health Services Commission. As the actuary has already done with the current "new eligibles" database in OHP, the current FHIAP database will be analyzed as a population similar to those that will receive coverage under the expansion. Various benefit packages, including the prevailing plans in the small group market will be analyzed using this new database. Oregon is interested in seeing if there are any differences in actuarial value for the same plan using these two populations. This could help to develop an estimate of expected utilization for the public and private sides of OHP2. Neither public nor private encompasses the entire target population of low-income uninsured, but both will become part of the overall OHP2 waiver.

Determining a method for benchmarking health plans by benefit categories is the next step, so current commercial plans can be compared. In IPGB's attempts to "cast a broad net" to maximize inclusion of more ESI plans that qualify for subsidy, they have agreed so far on a list of twenty-one (21) benefits that must be covered in some manner. Beyond the state mandated

[*] Please see IPGB comparison spreadsheets at *www.ohppr.state.or.us/Waiver_Application/index_waiver.htm.*

requirements, benchmarks of the details of coverage within a benefit category will not be specified.

The actuary under contract with the HRSA Team has been exploring the conceptual design for an electronic decision tool designed around a pass/fail approach by benefit categories and cost-sharing requirements that could compare plans against the benchmark. Ongoing use of such a tool could be useful for analyzing new plans as they come in to the healthcare insurance market and as trends in the market change.

CHIP Too (Access Model)

While Oregon will rely primarily on the traditional insurance model for low income Oregonians, CHIP Too will compliment insurance coverage for children who are eligible for OHP2 but are not yet enrolled. Unlike a traditional insurance model that attaches money to a person, CHIP Too directs money to the safety net provider serving the uninsured children. Safety nets will be required to have a schedule of discounts based on income. No one seeking services will be refused care due to an inability to pay for services. Although the CHIP Too proposal only includes access to primary care services with an emphasis on prevention, most safety net clinics have an established referral process to local specialty outpatient care, outpatient surgery, and inpatient care. If a child is eligible for OHP2 and has secondary and/or tertiary care needs, parents are more likely to complete the OHP2 enrollment process for their children.

Recently, Oregon Health Action Campaign (OHAC), an advocacy organization working toward affordable, comprehensive and quality health care for all, launched a campaign to try and improve hospital "charity care" policies and procedures. As a result of their work, Salem and Portland Metropolitan Area hospitals agreed to uniform policies and procedures for uninsured patients. They agreed to provide free care for people up to 150% of the FPL and a discounted rate for people from 150–200% of the FPL. The Oregon Association of Hospitals and Health Systems is working with OHAC to implement these policies in all hospitals throughout the state.

4.7 What is the projected cost of the coverage expansion? How was this estimate reached?

OHP 2 (Insurance Coverage Model)

The initial aim of the expansion concept was to expand coverage to 200% of the FPL. This income level is approaching Oregon's median income level. However, as HB 2519 evolved, that goal was reduced to 185% of the FPL. Most of the currently available projections are based on the original goal of reaching 200% of the FPL. Revisions will be provided to HRSA in a subsequent report in Spring 2002.

Because of the current economic and political climate in Oregon, including a $700 million budget shortfall, no additional funding could be allotted to fund the expansion. However, the overall Oregon Health Plan was treated generously, with a budget increase of 20%, the largest of any of the state department budgets. These increases are directed to maintain the plan and to cope with the rising cost of prescription drugs. The following outlines cost calculations and assumptions that went into cost projections.

Cost calculations:

- The per capita cost associated with coverage for current "new eli determined. These are the "OHP Adults and Couples" and "OHP Families" groups. There are no children or pregnant women in these groups. Per Capita costs are based on the work of the independent actuary used for rate setting in the OHP.
- The actuarial value of OHP Standard was assumed to have a value at 78% of the current OHP package.
- FHIAP adults costs were assumed to be at 78% of the "new eligibles" current per capita costs
- Estimates of premium contributions were determined following the FHIAP format.*
- Costs for the current OHP adults at the 78% of the current per capita cost was then combined with the cost for the FHIAP adult enrollees to estimate costs under the expansion.
- The total state contribution used to fund the OHP "new eligibles" at the current 100% level was combined with the state funding for the adults in the FHIAP program. This amount was then considered the state contribution that would be eligible for federal match.
- Additional costs were estimated for start-up and ongoing administrative operational costs.

Utilization assumptions:

Determining the number who are eligible and who will take up coverage by enrolling in the public OMAP or the FHIAP programs was determined using a saturation rate. This is the percent of the entire Oregon population (insured and uninsured) in the target eligible group who are expected to end up with coverage. This rate was key in estimating utilization in the OHP2 expansion and included the following assumptions:

- The target population is based on 1998 Population Survey data currently which will be updated with 2000 data as it is available.
- With system-designed incentives to obtain health coverage and the availability of OHP expansions, OMAP is anticipating a saturation level of Oregonians with incomes below 185% of the FPL that is equivalent to the highest level of saturation of any currently covered OHP group of eligibles.
- Expansion will not cover persons eligible for Medicare, even if their income is below one hundred 185% of the FPL. Medicare eligibles are considered insured for this cost estimate.
- Participants in existing OHP programs will increase due to the system-designed incentives to obtain coverage. Eligibles that are new to existing programs are identified as "outreach eligibles."

* See Section 4.5 of this report for more information of determining per capita costs.

- Participants in the current OHP Adults/Couples and Families program, and any additional eligibles who come in as a result of outreach, who would have usually fallen into the OHP Adults and Couples, or the OHP Families category, will be covered under the OHP Standard package
- The OHP Standard program will be opened to uninsured adults up to 185% of the FPL. However, it is likely that the number of adults that will be covered under the expansion will be capped at budget levels in order to avoid program deficits.
- Pregnant women and their newborns will be expanded up to 185% of the FPL. CHIP for children under the age of 19 will be expanded up to 185% of the FPL. All pregnant women, children and all "categorical" eligibles will be covered under OHP Plus, the same benefit level as the current OHP benefit package and will not move to OHP Standard.

Overall projections:

Considering these initial pricing assumptions on utilization, premium contributions and current costs, as well as keeping the OHP Program at budget neutrality for the 2001–2003 biennium, the following number of people can be served:

- Total OHP eligibles (with retroactive eligibles) included in the 2001–2003 budget is 416,777
- Total number of FHIAP enrollees for the 2001–2003 biennium is 4,000
- The proposed expansion as outlined in HB 2519 at 185% of the FPL is 41,345 with 4,779 children and 36,566 adults

CHIP Too (Access Model)

The state proposes using $5 million from its annual allocation of approximately $40 million federal SCHIP dollars, which will be matched by a state or local contribution of $1.6 million. The entire amount will be divided according to the standard CHIP split of 10% for administration and outreach and 90% for program activities. Pending approval, Oregon estimates that 12,500 children will receive primary and preventive services through this approach.

The amount requested is based on estimates of need and capped until this alternative coverage approach has been piloted and evaluated. The amount could vary in subsequent years based on the success of the program. It will be implemented to complement the OHP2 insurance coverage model expansion and the overall Oregon Health Plan.

4.8 How will the program be financed?

OHP 2 (Insurance Coverage Model)

The OHP2 expansion will be financed through a combination of savings from reduced benefits for some adults now covered under the OHP and increased federal matching funds. In effect, costs per person for roughly 90,000 current OHP adults will be reduced and federal match will be gained for as many FHIAP enrollees as possible.

All of the pricing and financing estimates were determined during the legislative session. Most of the projections at this time reflect the original goal to expand to 200% of the FPL, rather than the final compromise to expand to 185% of the FPL. Assumptions that were made for the original pricing may change as the program is designed more fully. Revisions will be documented in the subsequent report in Spring 2002.

The financing assumptions that were used to achieve budget neutrality in the 2001–2003 biennium, include:

- Start date of October 1, 2002.
- Phase-in of new eligibles (expansion and outreach) completed by 6/30/03.
- Reduction in benefits for some of the current OHP adults is currently estimated to be around 22%, so that the benefit package value 78% of the current OHP package for adults in the categories of OHP Adults/Couples and OHP Families.
- Besides those in the categories of OHP Adults/Couples and OHP Families, those getting OHP Standard include FHIAP adults, outreach enrollees (previously eligible but not yet enrolled persons), and new adults who come into OMAP or FHIAP programs.
- Children and pregnant women will get OHP Plus (using either Medicaid or CHIP dollars as applicable under OMAP rules, so that some will be covered at the higher CHIP match rate of 70% federal and 30% state dollars.
- The same per capita costs were assumed per person to cover an enrollee in the FHIAP program as it would cost to cover them in the public OHP Standard program.
- State per capita costs were estimated using the current FHIAP subsidy structure, outlined in Section 4.5, which will vary by different groups and income levels.
- The saturation rate would be at the highest level of any currently covered OHP group of eligibles and is estimated to be about 83%.
- Costs would include the cost of direct care of the expansion and outreach populations, start-up costs, and administrative operational costs,
- Federal match would be available on all of the FHIAP dollars.

Using these assumptions, the financing scenario is as follows:

- The combination of the OMAP savings from the reductions in the benefit package and the federal match for FHIAP expenditures would result in a state contribution of $27.3 million to fund additional outreach and expansion eligibles.
- With the match rate depending on the number under CHIP and under Medicaid, this would translate to $60.4 million available in total funds to finance the expansion.

CHIP Too (Access Model)

The State proposes to use $5 million from its annual SCHIP allocation of $40 million that will be matched by a state or local contribution of $1.6 million. It is anticipated that 65% of the $2.2

million that was allocated to the safety net by the legislature over the next two years will be part of the $1.6 million. Additionally, Oregon Counties and School Districts have expressed a potential interest in providing local contributions in order to stabilize school based health clinics and County Health Departments providing primary care.

4.9 What strategies to contain costs will be used?

OHP2 (Insurance Coverage Model)

The State of Oregon is committed to increasing access to basic health care services provided through Medicaid, the Children's Health Insurance Program or private insurance for uninsured Oregonians with an income of up to 185% of the FPL. These expansion efforts are budget neutral and require cost containment strategies in order to serve approximately 50,000 more Oregonians. Current trends, however, in rising health care costs create concern for:

- The future sustainability of the Oregon Health Plan and the private insurance market;
- Individuals unable to pay for all or part of the costs of their health care;
- Employers providing health care coverage for their workers and their dependents;
- Health care providers providing services; and
- Insurers and other organizations providing health care coverage.

Complex factors affect the balance between public and private health care programs and need to be better understood in order to establish policies that result in access to health care and health care cost containment. These factors include, but are not limited to:

- Whether the current structure of Medicare, Medicaid and the private insurance market is cost-sustainable;
- The reasons behind general health care cost trends;
- Appropriate reimbursement methods that reduce cost-shifting and optimize access to providers and plan choices;
- Whether public programs for low-income Oregonians that ensure adequate coverage are cost-effective and provide a realistic transition to private coverage; and
- Whether private coverage that is affordable offers sufficient benefit choices and is based on a market-based system.

In order to contain costs that address these complex factors, Oregon's new health care expansion policy indicates that:

- The respective roles and responsibilities of government, employers, providers, OHP enrollees and the health care delivery system must be clearly defined;
- The State, in partnership with the private sector, move toward providing affordable access to basic health care services for Oregon's low-income, uninsured children and families;
- The State will provide subsidies to low-income Oregonians, using federal and state resources, to make health care services affordable to low-income, uninsured

Oregonians. These subsidies are subject to available funds and need to encourage the shared responsibility of employers and individuals in a public/private partnership;

- All public subsidies must to be clearly defined and based on an individual's ability to pay, not exceeding the cost of purchasing a basic package of health care services, except for those individuals with the greatest medical needs;
- The health care delivery system needs to use evidence-based health care services, including appropriate education, early intervention and prevention, and procedures that are effective and appropriate in producing good health;
- There will be minimal cost sharing for preventive and primary care, leading to earlier diagnosis and less expensive procedures as compared to specialty/inpatient care required when treatment is begun later in the disease process.

The Oregon Legislature also approved a number of measures designed to improve the quality and control the costs of prescription drugs in Medicaid. Likely approaches include:

- Creation of a reference based formulary encouraging the use of cost effective drugs
- Selection of specific pharmacies for Medicaid patients
- Improvement in information systems involving prescription drugs
- Case management of patients using multiple medications

CHIP Too (Access Model)

Oregon plans to launch the CHIP Too program in a modest fashion. The State anticipates that CHIP Too will cost $6.6 million. CHIP Too will operate within the federal SCHIP allocation and state and local matching dollars. Oregon will review the success of the model and expand it if proven to be worthwhile and cost effective. CHIP Too aims to reduce more expensive care by providing primary and preventive services.

CHIP Too aims to increase access to quality and continuous care by compensating safety net clinics for serving Oregon's children who are eligible but not yet enrolled in OHP2. Reimbursing safety net providers for the care provided to these children will allow them to serve more people, including children, who do not meet the OHP2 eligibility criteria. It is anticipated that by providing more services that are culturally and linguistically appropriate, there will be less downstream costs of emergency department services and hospitalization. Similar models in communities across the country have demonstrated success in addressing health disparities and containing costs. For example, Indianapolis, Indiana showed a significant decrease in emergency department visits as well as inpatient use. Hillsborough County, Florida has an analogous program for the uninsured and has demonstrated similar success in reducing emergency department visits as well as improving the health of the uninsured with chronic illnesses. It appears that an "ounce of prevention" can indeed improve health and reduce costs.

The Department of Human Services (DHS) will review claims data to ensure that appropriate services are being provided. An advisory committee consisting of diverse stakeholders will examine utilization at an aggregate level and provide continuous feedback to participating safety net clinics to ensure cost containment. We believe that CHIP Too will encourage the evolution of a more accountable and predictable safety net system with improved information systems and

enhanced relationships with OHP2 carriers. More safety net clinics will become part of the delivery systems of OHP2 carriers. This organization and "systemization" will lead to more predictable and contained costs.

4.10 How will services be delivered under the expansion?

OHP2 (Insurance Coverage Model)

OHP2 services will be delivered in nearly the same way as the existing OHP delivery system. Enrollees must choose a managed care plan, unless:

- The enrollee is of American Indian/Alaska Native heritage
- The enrollee is not required to enroll in a medical plan.
- There are no medical or dental plans available where the enrollee lives.

If no medical plan providers are available within a specified number of miles, an OHP enrollee will choose a Primary Care Case Manager (PCCM) from a list provided by OMAP. A PCCM provides the same kinds of service as a health plan and acts as the OHP enrollee's primary care provider.

While all medical, dental, and mental health plans for OHP Standard must provide the same "basic" services, all plans are not alike. OHP enrollees are not allowed to change health plans until renewing their application, unless there is a special reason. An OHP enrollee may delay enrolling in a medical plan if seeing a provider who is not part of an available medical plan and:

- Has surgery scheduled; or
- Is in the last three months of pregnancy and not currently enrolled in a Medical Plan.

An OHP enrollee may delay joining a dental plan if seeing a provider who is not part of an available dental plan and if the OHP enrollee has dental surgery scheduled. All requests to delay enrolling in a managed care plan must be made in writing along with the OHP application.

Every enrolled family member must be in the same medical and dental plan. However, family members can have different Primary Care Providers (PCP). A mental health plan will be assigned based on the medical plan chosen.

To assist OHP enrollees choose the plan to best meet their needs, they are encouraged to call potential health plans and ask questions about factors that are important to them, such as which health care providers, clinic sites, hospitals, pharmacies and mental health arrangements they will have to use if joining a specific medical plan. Plans have different rules about referrals to specialists, which can affect the use services. If enrollees are already connected to primary care clinics or providers, they are encouraged to call and ask which Medical Plan the PCP or clinic belongs to.

Oregon experienced a decade of substantial participation in Medicaid by commercial HMOs. As utilization and risk increased, and relative reimbursement fell, commercial plans retreated from Medicaid markets. There has been a notable decline in the number of OHP enrollees being served by Fully Capitated Health Plans (FCHP). Many of these commercial plans have been

replaced by "community-oriented" health plans that are provider owned, mostly Medicaid-only HMOs. Most plans provide care for all the patients in a community, removing selection as a factor and, as a result, have been successful in enlisting the participation of physicians and equitably distributing the risk. This balance is tenuous, particularly with increasing prescription drug costs.

Two OHP carriers are of special interest in terms of their delivery system strategies—CareOregon and Central Oregon Independent Health Services (COIHS). Both are fully capitated Medicaid HMOs. COIHS, owned by physicians and hospitals, has become licensed as a health service contractor and also provides a Medicare+Choice option to central Oregon seniors. COIHS has organized services for a large portion of the state—rural and urban. Stability and access for Medicaid has increased significantly as a result.

In Portland, CareOregon emerged as a cooperative venture between safety net clinics, counties and Oregon Health Sciences University. CareOregon is also a Medicaid only HMO. As HMOs and insurers have retreated from Medicaid, CareOregon has stepped up in the state's largest market, Portland, while continuing to serve several smaller markets throughout Oregon.

CHIP Too (Access Model)

The Chip Too model is tailored to meet the needs of children eligible but not yet enrolled in public insurance. The proposed CHIP Too compliments OHP2 by offering an alternative and interim coverage model for uninsured children that provides access to primary and preventive health care services. Oregon currently provides retroactive eligibility for inpatient hospital services for children. Specifically, the CHIP Too approach will:

- Ensure primary health care is available to children while their parents apply or reapply for public insurance programs;
- Provide primary care, with an emphasis on preventive services, to uninsured children at qualified safety net clinics; and
- Offer eligibility screening and enrollment assistance for OHP2.

Oregon's health care safety net provides health care to a significant portion of Oregonians who are uninsured or on the Oregon Health Plan (OHP). In 1999, according to DHS and Oregon Primary Care Association* data:

- An estimated 146,000 Oregonians received safety net services.
- Services were provided to 56,000 OHP enrollees and 90,000 uninsured Oregonians.

The HRSA Team used the definition of safety net created by Oregon's Committee on Health Care Safety Net Support. The statewide Committee includes more than 100 providers, advocates, and government officials, and works collaboratively and strategically to strengthen, support and expand the role and financing of the safety net. The Committee's definition states that Oregon's safety net is comprised of a broad range of local non-profit organizations, government agencies, and individual providers who share the common mission of delivering health care to persons who experience barriers to accessing the health care they need. In addition, safety net providers have

* For more information on the Oregon Primary Care Association, see *www.orpca.org*.

a substantial share of their patients as the uninsured, Medicaid and other vulnerable Oregonians. The safety net does not turn anyone away because of an inability to pay. These providers are committed to keeping Oregonians healthy and productive members of the state's work force.*

The health care safety net is comprised of:

- Federally Qualified Health Centers, i.e., Migrant Health Centers, Community Health Centers, Health Care for the Homeless programs
- School-based health centers
- Indian/tribal clinics
- County health departments
- Rural Health Clinics
- Community-based or "free-standing" clinics
- Other providers committed to serving the underserved

Safety net clinics in Oregon are staffed by a combination of physicians, nurse practitioners, nurses, dentists, social workers, community outreach workers and other health care providers, including volunteers. The clinics offer health services to low-income people, including those without insurance, but most patients do pay a sliding discounted fee or receive care covered by OHP, Medicare and private insurance. Primary care services provided by the safety net vary but frequently include urgent care, acute and chronic disease treatment, services such as mental health, dental, and vision, reproductive services, preventive care, well child-care and enabling services (translation/interpretation, case management, transportation and outreach).

Oregon's safety net clinics differ in size, employees, clientele, service area characteristics and demographics, stability of revenue sources, and sophistication in business management practices. They also fluctuate in their ability to collect and use data. To help integrate and strengthen the safety net, Oregon Community Health Information Network (OCHIN), a statewide network, was organized in September 2000. OCHIN is a HRSA Community Access Project grantee and currently sponsored by CareOregon, The Oregon Primary Care Association (OPCA), the Department of Human Services, all FQHCs in Oregon, as well as some county health departments, school based and free standing clinics.

OCHIN's vision is to be a jointly owned and operated management services organization providing practice management and information services as well as other support services to member safety net clinics. In the spring of 2001 a web enabled practice management and electronic patient records system was purchased by OCHIN after a careful review of Oregon safety net provider's informational needs. Twenty safety net providers have agreed to join OCHIN and participate in its practice management and electronic patient records system. It is anticipated that additional safety net providers will join as OCHIN further develops. OCHIN will assist the safety net in improving their ability to organize information and coordinate with other health care providers and services.

* For information on the health care safety net, see *www.ohppr.state.or.us*.

In order to provide care in a complex health care industry, the safety net depends on diverse funding streams. A few community-based safety net clinics do not bill for services delivered or receive any federal government dollars. Oregon's safety net is financially supported through:

- Federal grants
- OHP/SCHIP reimbursements
- Medicare reimbursements
- State and local government grants/contracts
- OHP carrier contracts
- Private insurance reimbursements
- Patient fees
- Foundation grants
- Private donations

The CHIP Too approach will provide the safety net with another stable source of funding thereby improving access, predictability and accountability. Ongoing interaction will encourage both safety nets and OHP carriers to expand their current relationship. If CHIP Too is successful safety net clinics and OHP carriers will consider further collaboration on the provision of specialty and outpatient hospitals services.

4.11 What methods for ensuring quality will be used?

This section will outline the expansion in terms of performance measures for the quality of health care and patient health status. Additional aspects of the structure and processes of the proposed expansion models will be addressed under the Program Evaluation Section.

OHP2 (Insurance Coverage Model)

The current models of expansion consist of two separate approaches for increased insurance coverage due to passage of HB 2519:

- *Public side:* OHP Plus (same as current OHP) and a more basic OHP Standard plan.
- *Private side:* subsidized premium share program similar to current FHIAP using a benefit benchmark plan or plans for qualifying for subsidy.

Each of these strategies bring unique features that may impact the quality of care as well as challenge how monitoring the delivery of care. The HRSA Grant Team reviewed the original 1115 Waiver from 1991, current monitoring of quality of care in the public and private sector, and the structure of each new expansion model. The coverage model expansion results in four general populations that need to be assessed regarding quality of care and patient health status. These four populations are:

- The "categorically eligible," including pregnant women and children who will remain on the current OHP, to be renamed OHP Plus
- "New eligibles" of the current OHP as they switch to OHP Standard and may face challenges to health care access.

- Current FHIAP enrollees, who may be affected if their current subsidized plan does not meet the benefit benchmark plan(s).
- The previously uninsured population that will come in under both the private and public side of OHP2.

Within each of the four broad groups there are defined subgroups that need additional monitoring. In the original OHP waiver, there were only two separate populations; Phase I which was the "new eligibles" but included pregnant women and children, and Phase II, which were the more vulnerable (aged, people with disabilities, etc.). OMAP has continued to monitor these original two subpopulations, as well as subcategories within each of the two Phases. These need to be taken into account in monitoring the new expansion.

The HRSA Grant Team reviewed current quality monitoring at OMAP, the Oregon Health Division, and statutory requirements of private insurance carriers. The Team recommends the following health care quality measures:[*]

- Access to care, includes monitoring of provider participation, reported access and availability of care under the program, and utilization measures.
- Provider adherence to accepted clinical practice standards; would include monitoring each of the four population groups to assess if they are receiving "sentinel" preventive and healthcare screening services following accepted clinical guidelines.
- Health status, would include monitoring of enrollee perception as well as looking at health outcomes for the above-mentioned "sentinel" conditions in provider records.
- Perceived quality of care by enrollees, would include reporting of overall satisfaction with the quality of care of the enrollees receive, compared to care received prior to the demonstration.

Challenges in ensuring quality in the coverage expansion:

There are multiple difficulties in obtaining information to assess quality in most healthcare programs. The unique features of this expansion, a private and public partnership, make the monitoring of quality of care challenging. While many of the quality activities proposed are currently being done in the publicly-sponsored programs of OHP, and may also be collected in the private insurance realm, there is not a statewide means of combining public and private efforts.

Since the start of the Oregon Health Plan, Oregon has been pursuing methods for assessing and reporting on the quality of managed health care. OMAP, as part of the original waiver requirements, has activities and processes to monitor, evaluate and improve quality and access to healthcare.[†] These activities will remain in place to monitor the public side of the insurance coverage expansion model.

[*] For more details, see "Quality of Care and Patient Care Status" at *www.ohppr.state.or.us*.
[†] For more information on OMAP and its quality monitoring, go to *www.omap.hr.state.or.us*.

There are private insurance requirements by state statute. Under Senate Bill 21 (1997), the Office for Health Policy and Research (OHPR), organized an advisory consortium, Oregon Health Outcomes Network. Working in partnership with the Oregon Coalition of Health Care Purchasers (OCHCP), the first Oregon community-based managed health care performance report was completed. The OCHCP conducted a survey using the Consumer Assessments of Health Plans (CAHPS) to evaluate what members and their employee groups think of the health plans they are in and the medical care they get. The Health Plan Quality from the Consumer's Point of View surveyed over 3,000 managed care health plan members, comparing 11 HMO's and PP0's in the Portland Metropolitan Area.[4]

The Oregon Health Outcomes Network also developed recommendations for clinical quality measures, after a series of meetings, surveys and polls, prioritizing a short list of nine measures from which the final four measures were chosen. All of the measures selected were contained in the National Committee for Quality Assurance (NCQA) Health Plan Employer Data and Information Set (HEDIS). By selecting these, it provided standardized definitions and data collection protocols, increasing the opportunity to collect comparable clinical data across multiple managed care health plans. The measures selected:

- Preventive: childhood immunization and tobacco use
- Chronic: diabetes
- Acute: pregnancy care

Effective November 1998, each insurer offering managed health care insurance in Oregon is required to report on these measures as part of its annual report on quality assessment activities made to the Department of Consumer and Business Services (DCBS). It is still difficult to use the information for straightforward comparisons.

The Oregon Coalition of Health Care Purchasers (OCHCP) continues to build upon this past work. It has incorporated the Leapfrog Initiative's quality approach into their members' Request For Proposal (RFP) for carriers.[*] OCHCP continues to champion quality through their Health Care Quality Corporation, working with the Oregon Diabetes Coalition to develop a compatible diabetes tracking system throughout Oregon. The Public Employee's Benefit Board recently used the OCHCP quality measures, including the Leapfrog Initiative, in their RFP for carriers.

As FHIAP develops standards for qualifying for subsidy, they have an opportunity to include quality measurements reporting requirements. Except for ongoing participation in other OHP programs, past certification has had minimal requirements. The federal government will most likely require quality monitoring and assessment on the private side in order to receive matching dollars such as is expected on the public side.

There are unique features of the private and public partnership that need to be considered as work continues to implement the new expansion insurance coverage model. These include:

- *Larger or different public health role* (i.e. state and county public health departments)? How could it serve as a bridge in the gap between public and private

[*] Leapfrog Initiative information available at *www.leapfroggroup.org*.

coverage quality monitoring? How can public health agencies provide a stronger focus on both individual and community-based prevention efforts?

- *Mental health parity issues?* Some of the subsidized plans won't have full parity in comparison with current OHP. How will impact on health outcomes be assessed?
- *Affordability issues?* With the addition of OHP standard, a plan with more cost sharing, there are issues of affordability. Should Oregon measure the impact on quality of care (and how)?
- *Ethnic and cultural issues?* Are there additional potential cultural or linguistic barriers that need to be monitored due to the new OHP Standard design? How can outreach to vulnerable communities be improved?
- *Public versus private issues?* Practices vary between the public and private sector in measurement and collection of quality measures already. How can collaboration be improved?

CHIP Too (Access Model)

Most safety net providers already are Medicaid providers and therefore adhere to existing methods for ensuring quality. Currently,

- Safety net providers who participate in OHP2 adhere to Title XIX standards.
- Federally Qualified Health Centers (FQHC) and Rural Health Centers (RHC) are audited by OMAP for appropriateness of services.
- FQHCs have federal clinical quality audits.
- Indian Health Services clinics have federal audits.
- School-based health centers adhere to "Oregon's School-Based Health Center Program Standards" administered by the DHS Health Services Cluster.
- The Joint Commission on Accreditation of HealthCare Organizations (JCAHO) certifies some safety net clinics.

CHIP Too hopes to ensure additional quality of services by:

- Increasing patient access to, and satisfaction with, the health care delivery system;
- Providing well trained and credentialed staff that are culturally competent;
- Delivering appropriate, comprehensive, and continuous clinical care;
- Improving health outcomes of vulnerable populations; and
- Eliminating disparities in access to quality care.[5]

Some safety net providers do not have the administrative capacity to collect and report data in a sophisticated fashion. In order to participate in CHIP Too, these providers will need to develop administrative capacity so that data reporting is adequate to maintain accountability for the use of government dollars and for determining the effectiveness of the CHIP Too program. It is expected that a portion of the SCHIP and CHIP Too administrative allotment and/or the Oregon Legislature's allocation of $2.2 million will be devoted to assist these providers in developing infrastructure. In addition, the new Oregon Community Health Information Network (OCHIN)

funded by a Community Access Program HRSA grant will improve safety net practice management capability by building a statewide data warehouse. The warehouse will support the collection and analysis of safety net services used to ensure continuous quality improvement efforts.

4.12 How will the coverage program interact with existing coverage programs and State insurance reforms (e.g., high-risk pools and insurance market reforms), as well as private sector coverage options (especially employer-based coverage)?

OHP2 (Insurance Coverage Model)

OHP2 will interact with all parts of the private and public health care system in Oregon. Public coverage of categorically eligible populations and other vulnerable populations (i.e., TANF and GA) will remain the same. Oregon believes that the interest and attention paid to OHP2 will generate additional categorical eligible enrollees.

Adults and couples whose incomes rise above 100% of the FPL will remain eligible for the plan under OHP2. This is the largest group of individuals currently losing eligibility. Some currently covered will elect to not continue enrollment. Some of these individuals will remain uninsured, choosing to depend on the safety net, although the total number of covered lives will increase, likely decreasing safety net and emergency room care overall. It is likely that sicker adults will continue enrollment in OHP Standard, potentially increasing the risk for OHP carriers while continuity of care will improve, decreasing risk for OHP carriers. Utilization of safety nets for care may increase. Use of prescription drugs, primary and preventive care may increase.

Oregon will be able to do more outreach to uninsured children, leading to a decrease in the overall number of uninsured children. When parents have more continuous coverage it is likely children will do the same. More pregnant women will have coverage; more women will continue coverage after pregnancy due to expanded income eligibility. Complications of pregnancy will likely decrease and birth outcomes improve.

Oregon will be able to insure more people for less using employer contributions. FHIAP will emphasize group coverage and de-emphasize individual coverage. FHIAP dollars will be used more efficiently when combined with employer dollars. The Oregon Medical Insurance Pool (OMIP) will stabilize enrollment because of FHIAP's emphasis on group coverage and the availability of public individual coverage at higher incomes levels.[*]

The individual market will stabilize but given current rejection trends may shrink in size and present opportunities for new entrants in that market. The large group market will stabilize to some degree as expansion reduces cost shifting and cost sharing reduces inappropriate use. The small group market will continue turbulent. Some small groups may be stabilized as enrollment rates increase with subsidies but guaranteed issue and age rating will continue to cause very significant increases in premium. Legislation creating basic benefit approaches for small group could help but further reforms will likely be needed.

[*] Twenty percent (20%) of FHIAP is currently in OMIP and almost half of OMIP enrollees have incomes below 200% of the FPL.

Providers will evaluate the pros and cons of two different delivery approaches—a cooperative community approach on the OHP/public side and a competitive, market based approach on the private side. Employer based coverage will reflect the state of the economy not the state of health reform. If the economy improves and competition for workers continues employer-based coverage will be stable or increase. If those trends are not improving employer-based insurance will decrease. Premium rates will be a factor; OHP stability and decreased cost shift will reduce premiums. OHP2 will also help, but any changes due to OHP2 will be dwarfed by overall economic conditions.

Focus on benefit options, public/private partnerships, and cost sharing will force Oregonians to confront health care choices. The relationship between cost and coverage will be more overt. Oregon will focus further on benefits as difficult tradeoffs will need to be made in the expansion decision process. Concerns around cost and insurance coverage will be taken more seriously as a result and continued attempts at expanding coverage and reform of health care will continue.

CHIP Too (Access Model)

Acknowledging that some Oregonians will be without health insurance, a variety of stakeholders including state government officials, designed CHIP Too, a complementary access coverage model. CHIP Too program will *not* replace the OHP2 insurance coverage model; it will complement OHP2 coverage. CHIP Too proposes to meet the needs of children eligible but not yet enrolled in public insurance, with safety net clinics as the point of access to primary care and preventive services.

In order to assure that those eligible but not yet enrolled in OHP2 are encouraged to enroll in public insurance programs, safety net providers participating in the proposed CHIP Too program will:

- Promote and assist in OHP2 enrollment through culturally appropriate education regarding the importance of private and public health insurance;
- Provide OHP2 eligibility screening;
- Assist with the OHP2 application; and
- Actively participate in outreach for OHP2

Safety net clinics participating in CHIP Too will make formal agreements to refer children, when appropriate, to local specialty outpatient care, outpatient surgery, and inpatient care. Secondary and tertiary providers will refer uninsured children to the safety net provider.[*] If an uninsured child, for example, inappropriately accesses an emergency department, the emergency department provider will refer them to their local safety net clinic. Safety net services provided to children who are eligible but not yet enrolled in publicly funded insurance programs will be compensated by the State. In-patient care, for children eligible but not yet enrolled, will continue to be compensated through Medicaid retroactive eligibility.

[*] For more details, see "Community-Based Diagram" at *www.ohppr.org/hrsa/index_hrsa.htm*.

4.13 How will crowdout be avoided and monitored?

OHP2 (Insurance Coverage Model)

States have used various strategies to prevent or reduce the occurrence of crowd out, including:

- Trying to establish affordability of private coverage, using cost sharing mechanisms, such as premiums, co-pays, and annual deductibles.
- Requiring periods of uninsurance, or a "look-back period," which may range from several months to a year or longer.
- Providing subsidies to employers or employees for purchase of insurance coverage.
- Limiting the scope of benefit packages.[6]

The Office of Medical Assistance Programs (OMAP) has the functional responsibility for the OHP and relies on the offices of the Adult and Family Services Division (AFS) to process OHP applications and track any third party payment. AFS receives notification about third party payments from three sources: medical providers, followed by the AFS Child Support Services Unit, and clients who call to relate their private insurance coverage.

One year following institution of the SCHIP program in OMAP, an informal audit was conducted by OMAP to assess occurrence of crowd out. There were not cost sharing aspects to the program, therefore OMAP instituted a waiting period of six months of uninsurance prior to enrollment in CHIP. The audit indicated that during a seven-month period in 1999, fewer than 30 people per month on average were denied coverage due to having private coverage at the time, or within 30 days, of the application date.[7] At that time, income eligibility limits for SCHIP children in Oregon were 133–170% of the FPL from birth to age six. Children from ages 6–19 were included with incomes from 100–170% of the FPL.

Upon approval of the expansion waiver, several crowd-out strategies will be instituted:

- Subsidizing Employer Sponsored Insurance (ESI) coverage for low wage parents is intended to increase the "take up" rate by employees who have been unable to afford health coverage. By helping employees participate in the ESI, and making it possible for employers to include dependent coverage, employers should improve their ability to recruit and retain desirable employees. The experience from other states has shown that at income levels under 185% of the FPL employers are not likely to institute substitution of their health coverage with public programs' coverage.
- Cost sharing will be instituted under the new OHP Standard, decreasing the incentive to move to public coverage. A reasonable benefit "bridge" from private to public coverage is critical to the success of this strategy.
- Flexibility around eligibility will allow Oregonians the ability to choose private or public coverage depending on a variety of factors, not just benefits.

CHIP Too (Access Model)

The Department of Human Services and the CHIP Too Advisory Committee will be responsible for monitoring CHIP Too crowd-out as well as developing strategies to avoid it. It is likely,

however, that crowd out will not be an issue for the proposed CHIP Too model for several reasons:

- CHIP Too outreach efforts will focus on OHP2 enrollment.
- The proposed CHIP Too program only applies to primary care and preventive services and therefore offers a less rich range of benefits.
- Safety net clinics offering CHIP Too services have a schedule of discounts that may involve more cost sharing for a patient than the OHP Plus.

CHIP Too is not a continuous coverage program. Children (or their parents) must reapply at the time of each visit.

4.14 What enrollment data and other information will be collected by the program and how will the data be collected and audited?

OHP2 (Insurance Coverage Model)

If Oregon's OHP2 waiver is approved, it will be necessary to collect data to show whether crowd out is occurring. Relevant data derive from several public agencies:

- *Enrollment data*—DHS agencies and funded programs that conduct eligibility and enrollment procedures with clients who qualify for OHP and SCHIP
- *Employee and Employer data*—the Employment Department collects data on an annual basis about Oregon businesses, employees and such information as type of firms, their characteristics, wages and benefits provided, and profitability.
- *Insurance Industry data*—the Department of Consumer and Business Services, Insurance Division certifies insurers who do business in Oregon.

Enrollment and claims data:

The Department of Human Services (DHS) is the central agency for programs that provide services to clients, including:

- Oregon Medical Assistance Program (OMAP)
- Adult and Family Services Division (AFS)
- Senior and Disabled Services Division (SDSD)
- Services for Children and Families (SCF)
- Mental Health and Developmental Disability Services (MHDDS)
- Oregon Health Division (OHD)
- Office of Alcohol and Drug Abuse Programs (OADAP).

All of these programs belong to the DHS Management Information System, but multiple database systems exist. The exception is OADAP, which is in a combined Client Management Information System (CMIS) with the Mental Health Division. Enrollment, disenrollment and claims payment data for the OHP are reported to OMAP that maintains the main database on

OHP client activity. OMAP prepares its biennial budget for the legislature using fiscal data from those agencies that provide programs for OHP clients.

Employment data:

Employment data is protected by federal rules protecting the privacy of employers and employees wage and tax information. Currently, the Employment Department (ED) conducts an annual survey of Oregon employers that provides information on health benefits offered by employers to employees. The Medical Expenditure Panel Survey (MEPS-IC) data will be used for state to national comparison of employer and employee insurance status. The ED also has regional offices where surveys and focus groups could be conducted to access particular specific local information about characteristics and behaviors of employers and employees related to health insurance benefits.

Department of Consumer and Business Services (DCBS):

The DCBS does not systematically collect data about the insurance needs of low wage, part time or seasonally employed persons. Domestic insurers, those who are insured under the laws of Oregon, could be a source of data about insurance needs of employers and employees, in partnership with the public programs. Providers and health plans also provide data to OMAP. Oregon could collect new information as a consequence of the restructuring of DHS and the incorporation of community-based delivery systems in several areas of the state. Primarily, data about Oregon's employees, employers, health insurance coverage needs and access are provided through national surveys, CPS and MEPS, in particular.

It is critical to identify "triggers" and an alert system, to quickly reveal whether/when crowd out is occurring. OMAP has constructed a rolling six-year table of the eligible Medicaid population, which is in ninety-day increments.[8] This allows DHS administration to project caseloads, and provides OMAP with the capability to assess churning patterns and trends. Currently, there is no data exchange about OHP clients on a regular basis with insurers, nor does that come under the responsibility of DCBS to require the sharing of client information. Data that are available from insurers are in aggregate form and include premiums collected, reserve money to pay claims, and covered lives.

CHIP Too (Access Model)

The State will collect utilization data and basic demographic information such as racial and ethnic status, age, and family income through the billing form. The DHS in partnership with a stakeholder advisory committee will consider other remaining data needs. The billing form shall be submitted electronically although accommodations will be made for safety net providers lacking the technology to submit electronically. The DHS will be responsible for receiving and reviewing monthly and quarterly reports to determine if billing and OHP2 enrollment screening clients is being conducted appropriately.

4.15 How (and how often) will the program be evaluated?

OHP (Insurance Coverage Model)

In order to assess whether the waiver implementation has produced changes in the programs and effectiveness of OHP delivery system, the program evaluation plan will compare data from the new OHP program and processes with results of most recent past studies. OMAP conducts regular and informal studies in accordance with federal regulations. These evaluations focus on maintaining and improving access, improving quality of care, monitoring consumer satisfaction and containing costs of providing health care for Medicaid and SCHIP populations. OMAP monitors and evaluates these processes directly through contracts with Managed Care Organizations (MCO) and by contracting with external organizations for specific evaluations. The Quality Improvement Team at OMAP conducts annual reviews, both desk audits and on site audits, of all MCOs, to measure access and quality of the delivery systems. One of the requirements by HCFA is that state Medicaid agencies that use a managed care delivery system have an External Quality Review by an independent, certified organization.

OMAP conducts other regular evaluation activities, including:

- Consumer Assessment of Health Plans Survey (CAHPS) through a contracted research organization;
- Contract Performance Measures using HEDIS and other measures;
- Encounter and Omission Data evaluation from the contracted MCOs;
- Government Performance and Results Act (GPRA) evaluation of the immunization rates;
- Review of Sterilization and Hysterectomy utilization and informed consents for compliance with HCFA standards.

Additional evaluation components recommended include:

Improved access to the OHP—OMAP will compare encounter and enrollment data after the waiver's implementation to pre-waiver data. OMAP data tables have been designed to allow trending of OHP enrollment and disenrollment activity on a rolling ninety-day basis.

FHIAP—FHIAP manages its own database, and will be able to compare its enrollment data with past enrollment figures. The evaluation plan should track the impact of various funding sources including those from newly established entities: Tobacco Settlement Funds Account, Health Care Trust Fund, and federal monies to subsidize purchase of employer sponsored insurance by low income employees.

Employer-sponsored insurance—Since the subsidized monies are intended to encourage small employers to continue offering and others to begin offering coverage for their employees, it will be important to assess their response to this initiative. Aggregate enrollment data for targeted employees who receive subsidies will be available through the Insurance Pool Governing Board (IPGB) that monitors enrollment in the private insurance market for publicly subsidized employees. Data will also be available for

FHIAP members and OMAP's SCHIP program encounter/enrollments. It would be helpful to access the Employment Department (ED) data on employers, but federal law protects that information. However, since the ED prepares an annual report on employment activity in the state, it might be useful to collaborate with the ED to add relevant questions about employee take-up and refusal rates of ESI following implementation of the waiver.

Outreach and education—It will be important for DHS agencies and FHIAP to inform all targeted populations of new incentives to purchase insurance and/or to enroll in publicly funded programs for health care/coverage. Outreach for Oregon's SCHIP program and FHIAP has been constrained previously due to inadequate funding to meet the demand. With implementation of OHP2, the state agencies can develop new marketing materials to encourage enrollment. The HRSA grant will evaluate the effectiveness of these outreach materials by measuring outcomes for increased family enrollments in private coverage.

Increased application/enrollment of eligible Medicaid populations—OMAP will provide annual and as-needed encounter/enrollment data to assess improved access and enrollment for Medicaid populations in OHP2 for income levels: 0–50% FPL (adults), 51–100% FPL (adults); and 101–185% FPL (adults). These data would be monitored at three-month intervals for comparison with previous enrollment data. Since there will be some type of cost sharing by enrollees in OHP2, the impact of cost sharing on application and enrollment patterns needs to be evaluated. Data should be collected on Medicaid applicants who either do not return forms, don't complete the application, and those who refuse participation for any reason.

In addition, there has been concern about administrative simplification with regard to the application and enrollment processes in DHS agencies. Changes made to the processes and the effectiveness of OHP Medicaid enrollments for appropriate populations with previous efforts will be compared in both outcomes and process evaluations. Collaboration with DHS agencies is important to develop an adequate performance evaluation mechanism.

Consumer satisfaction—OMAP currently participates in the national CAHPS survey of consumers of health care services through Medicaid managed care organizations. HRSA and OHPPR have recently conducted public meetings to understand health care access and affordability as experienced by consumers. The findings from these and other state-wide meetings could help design an Oregon-specific consumer assessment, that could be partnered with the outreach and education evaluation for a comprehensive, targeted strategy to improve knowledge and utilization of health care services in the state.

Audit—Although DHS is accountable for appropriate fiscal management of its agencies and contracted organizations for federal and state health care programs, the actual audit functions are housed in the Oregon Department of Justice (DOJ). OMAP, in particular, works closely with the DOJ attorneys to provide data and information about potential fraud and abuse of claims against the OHP. All staff are regularly updated on federal and state regulations for prevention of fraud and abuse. The Quality Improvement Team in

OMAP reviews the MCOs for proper encounter and claims payments, and reports irregularities to appropriate fiscal staff at OMAP. An Audit team, which is housed out of the DHS Director's Office, works directly with the DOJ attorneys for adjudication of claims problems. Monitoring and reporting evaluation of these activities in terms of the influence of changes in the OHP delivery system will be needed following approval of Oregon's waiver(s).

CHIP Too (Access Model)

In order to determine if CHIP Too is encouraging OHP2 coverage while providing quality care a formative evaluation will occur after the first year of its implementation. At the end of two years of operation a more comprehensive and formal review of CHIP Too will be conducted. Although the specifics of what and how CHIP Too will be evaluated have yet to be determined, OHPPR will provide leadership in the evaluation design and implementation. OHPPR will evaluate strengths, weaknesses and make recommendations on a variety of components of the CHIP Too model including program design, provider participation, effectiveness of outreach and linkages to OHP2, and the array of services actually provided.

4.16 For each expansion option selected (or currently being given strong consideration) discuss the major political and policy considerations that worked in favor of, or against, that choice (e.g. financing, administrative ease, provider capacity, focus group and survey results). What factors ultimately brought the state to consensus on each of those approaches?

OHP2 (Insurance Coverage Model)

All expansion options, both those selected and those not selected, were first weighed against principles and assessed for their effectiveness in meeting policy objectives. When the Oregon Health Plan was being conceived and designed a dozen years ago, a set of principles was agreed upon. These principles guided the development of the OHP in the early 1990s, and policies derived from those principles were made a part of HB 2519, the legislative authorization for the OHP2 expansion. These policies, as listed in HB 2519 state:

1) The state, in partnership with the private sector, move toward providing affordable access to basic health care services for Oregon's low-income, uninsured children and families;

2) Subject to funds available, the state provide subsidies to low-income Oregonians, using federal and state resources, to make health care services affordable to Oregon's low-income, uninsured children and families and that those subsidies should encourage the shared responsibility of employers and individuals in a public/private partnership;

3) The respective roles and responsibilities of government, employers, providers, individuals and the health care delivery system be clearly defined;

4) All public subsidies be clearly defined and based on an individual's ability to pay, not exceeding the cost of purchasing a basic package of health care services, except for those individuals with the greatest medical needs; and

5) The health care delivery system encourage the use of evidence-based health care services, including appropriate education, early intervention and prevention, and procedures that are effective and appropriate in producing good health.

Family coverage through Medicaid and CHIP Section 1115 waivers:

This option supports the policies identified above. An 1115 waiver offers the flexibility to reflect the realities of the marketplace and the family budget; this flexibility is lacking in such avenues as state plan amendments under either CHIP or Medicaid. Oregon's earlier attempt to qualify employer-sponsored insurance for federal match through a CHIP state plan amendment proved to be a strategic error. HCFA interpreted Title 21 to mean that a person eligible for Medicaid must go to Medicaid or forfeit federal match. Oregon was committed to informing all who might be Medicaid eligible of the additional benefits and reduced cost sharing that program offers over typical ESI. However, Oregon was not willing to tell families that had come forward seeking assistance in affording ESI that for some family members the only practical recourse to remaining uninsured was Medicaid. Just as important, inflexibility on benefits and cost sharing under both Titles 19 and 21 supported the pursuit of an 1115 waiver in Oregon's case.

In combining both CHIP and Medicaid in a single 1115 waiver application, Oregon will be emulating the approach taken by Massachusetts in its attempt to integrate employer-sponsored insurance and public funding under both Titles 19 and 21.

Research strongly suggests that children are more likely to receive the care they need when they have the same health coverage as their parent(s). Splitting a family between employer-sponsored insurance (ESI) for the parent(s) and Medicaid or Medicaid look-alike CHIP for the children does not serve the best interests of improving the health of those children. The significant disadvantage to permitting parents to cover their children through ESI rather than Medicaid or CHIP is that some children may go without services due to benefits not covered or because of higher cost sharing. Oregon is assessing options to permit parents to move eligible children from subsidized ESI to Medicaid or CHIP. The premise is that coverage under any part of the OHP (Medicaid, CHIP, FHIAP) should not trigger the "six months uninsured" provision since the risk of crowd-out will already have been addressed at the time of initial enrollment into the OHP.

Employer-sponsored insurance :

This option also supports the policies identified in HB 2519. Employer-sponsored insurance (ESI) strengthens the state's partnership with the private sector in expanding the number and percentage of Oregonians with health insurance. More particularly, this option supports the use of government subsidies to encourage the shared responsibility of employers and individuals, and serves to clarify the roles and responsibilities of Government, employers, providers, individuals and the health care delivery system.

Subsidizing ESI will make this form of coverage affordable to thousands more low-wage employees and dependents. This will increase employee participation (or "take-up") rate, which may well decrease the incidence of employers deciding to stop offering coverage, especially for dependents. Maintaining (or even increasing) the incidence of employers offering dependent

health coverage will help to prevent crowd-out (the substitution of government funding for employer contributions to the cost of health coverage for workers and dependents).

The potential disadvantage of this approach is that in subsidizing the employee share of ESI premium cost, a message may inadvertently be sent to employers that they will gain—and their employees will not suffer—if the employer contribution is decreased. If this were to happen, crowd-out would result since government subsidies would replace—dollar for dollar—lost employer contributions. This is the rationale for setting a minimum employer contribution level.

OHP Standard benefit package:

Oregon intends to develop a new benefit for those expansion eligibles who *do not* fall into one of the Medicaid eligibility categories:

- Aged
- Blind
- Disabled
- Children
- Pregnant women
- Parents eligible for cash grant (TANF, GA)

In effect, the new OHP Standard benefits will apply to adults whose circumstances make it reasonable to assume that they may be considered part of the workforce and are not "medically

OHP Standard has higher cost sharing and leaner benefits than OHP Plus (the very comprehensive benefit package that resulted from Oregon's rationing process). The OHP Standard benefit package has not yet been finalized, but the following characteristics have been suggested in Health Services Commission (HSC) discussions:

- Little or no cost sharing for preventive and primary
- Little or no coverage for vision care
- Limited dental coverage
- Significant cost sharing for prescription drugs (possibly with reduced cost sharing for generic drugs)
- Significant cost sharing for inpatient care
- Limits on patient responsibility for cost sharing annually

This option supports two of the policies identified in HB 2519. It assures that public subsidies will be applied to a basic set of benefits but with additional benefits for those individuals with the greatest medical needs. Also, it supports the delivery system in encouraging the use of evidence-based health care services without positing that one size fits all when it comes to benefits or cost sharing.

CHIP Too (Access Model)

Governor John Kitzhaber, who remains solidly committed to health care for all of Oregon's children, supports the proposed CHIP Too waiver as it aligns with the Oregon Children's Plan that focuses resources on front-end prevention and treatment instead of after-the-fact intervention. The goal of the Oregon Children's Plan is to screen all Oregon children and to provide follow-up support to those families who need and request it.[*]

A variety of efforts supporting and strengthening Oregon's safety net have helped bring the state to consensus on the CHIP Too approach. Oregon recognizes that all people don't value, understand or appropriately utilize the health insurance model. The Oregon Health Council, the primary advisory committee to the Oregon Health Plan Administrator, the Governor and the Legislative Assembly, passed a Resolution that indicates even with the most committed efforts to achieve universal coverage there are likely to be at least 5% of Oregonians without health insurance.[†] The Resolution states that thousands of Oregonians, both insured and uninsured rely on safety net clinics for their primary care and for referrals for specialty and inpatient care. Yet Oregon's safety net clinics are in jeopardy of losing the revenue necessary to maintain needed capacity to provide health care to Oregonians in racial, ethnic, and rural communities. Therefore the Council recommended assuring adequate and consistent funding for the safety net system.

Oregon's Committee on Health Care Safety Net Support organized themselves, in response to a request from the Governor. Safety net providers and advocates united to address stabilization and expansion efforts in order to continue to provide services to Oregonians who do not access the OHP insurance system. The Committee prepared a unified voice for Oregon's 2001 Legislative session. To prepare for the session the Committee considered medically underserved areas, health professional shortage areas, the locations of FQHCs (including migrant and community health centers and healthcare for the homeless), School-Based Health Centers, Rural Health Clinics, Indian and Tribal Clinics, Community-Based Clinics, and County Health Departments. Furthermore, the Committee examined types of health care services as well as rates of uninsurance by county. Committee members provided information regarding Oregon's safety net and the needs of people without insurance to State Representatives and Senators. As a result of the Committee's efforts as well as the efforts of Oregon's Office of Rural Health, CareOregon, and the Oregon Primary Care Association, legislation was passed to:

- Apportion $2.2 million to provide necessary financial support to the statewide safety net;
- Provide $3 million to School-Based Health Centers;
- Allot $9.2 million to implement a prospective payment system for reimbursement to Federally Qualified Health Centers and Rural Health Clinics serving Oregon Health Plan enrollees; and
- Allocate $15 million to establish a foundation that will provide grants to rural hospitals and clinics (excluding FQHCs).

[*] For more information on the Oregon Children's Plan, see: *www.governor.state.or.us/governor/hhslp/ocp.htm*.
[†] For more detail, see the "Safety Net Resolution" at *www.ohppr.org*.

The Committee on Health Care Safety Net Support continues to work with DHS on a remaining goal to improve support for the safety net within the DHS. The Committee has requested that DHS identify expertise to help sustain and strengthen the safety net. After a careful review of the strengths and challenges of Oregon's safety net the Committee requested a safety net home within DHS that:

- Provides a wide range of community building and financial tools;
- Assures effective local planning efforts through catalysis, assistance, and accountability;
- Interfaces with State and Federal programs; and
- Provides matching funds.

The Tri-County Communities in Charge (TCCIC)[*] project is another effort that contributes to the support of CHIP Too. TCCIC received both planning and implementation support from the Robert Wood Johnson Foundation. Partners for the TCCIC project include eleven community-based clinics and three county health departments as well as local hospitals and health systems. This urban coalition expends in excess of $12 million on the uninsured in each year. It is in its second phase of development and aims to develop and implement a transition of the existing safety net into an expanded and integrated system of care for the uninsured in the Portland Metropolitan area. In order to accomplish this, safety net providers, advocates, and local and state government officials are researching and designing:

- A s*afety net authority* to organize and govern the safety net system within the Portland Metropolitan area.
- An o*utreach and education program* to promote utilization of the safety net and other resources.

Additionally, representatives from the Tri-Counties Communities in Charge project and Oregon Health Action Campaign, Oregon's chief health care advocacy group, worked with Portland area hospitals to develop a uniform charity care policy and procedure for uninsured patients up to 150% of the FPL.

The Health Care Coalition of Southern Oregon (HCCSO) was established in 1990 to promote the health of low-income, working poor, and vulnerable persons in Jackson, Josephine, and Douglas Counties, through formalized systems of collaboration. HCCSO supports the unique role of community based health centers and public health services through the development and implementation of comprehensive health care system and reducing barriers to care for vulnerable populations.

These and other efforts from a multitude of health care providers, advocates, and local and state government representatives have influenced the State's willingness to pursue CHIP Too.

[*] For more information, see: *www.co.multnomah.or.us/health*.

4.17 What has been done to implement the selected policy options? Describe the actions already taken to move these initiatives toward implementation (including legislation proposed, considered, or passed) and the remaining challenges.

OHP2 (Insurance Coverage Model)

The 2001 Oregon Legislature passed HB 2519 in July 2001, calling for the preparation and submittal of a Section 1115 waiver allowing Oregon increased flexibility on benefits and eligibility. HB 2519 calls for a new OHP Standard benefit plan for Oregonians who are currently eligible for the OHP only because of the current demonstration waiver awarded in 1994, and for non-pregnant adults in the OHP2 expansion population. HB 2519 also calls for a balanced approach to subsidies for ESI and for Medicaid and CHIP, with the family having substantial latitude for decisions about which options are most appropriate for all family members.

This summer, Oregon held a series of community meetings across the state.[*] At these meetings, Oregonians offered their insights and opinions on how the Health Services Commission should decide which benefits are covered under OHP Standard, and on how much cost sharing is appropriate for each benefit type, for families at various income levels. These meetings used a public education presentation and small group discussion materials to stimulate discussion focused on the appropriate benefits and cost sharing issues. Oregon will soon submit its Section 1115 waiver application to CMS. This application will request the latitude necessary to test the policies set forth in HB 2519, and to implement a coverage expansion suitable for Oregon's political ethos, health care marketplace, and revenue picture. This application assumes an implementation date of late 2002.

The challenges that remain in achieving the OHP2 expansion are:

- Secure the necessary Section 1115 waivers
- Maintain and build on the consensus and political will that made HB 2519 tenable.
- Complete the design of the OHP Standard benefit plan and develop benchmarks suitable for qualifying appropriate ESI benefit plans for subsidy
- Adapt the current OHP delivery system to include the appropriate balance of commercial insurers, community-based health plans, and primary care case managers/safety net clinics to serve the expansion population

CHIP Too (Access Model)

Oregon's safety net providers, advocates and government officials have been working diligently to sustain and strengthen the safety net. The Oregon Department of Human Services submitted an 1115 waiver request, *CHIP Too: A Strategy for Expanding Access to More Uninsured Children* in June of 2001. To prepare for the CHIP Too program, an advisory committee representing safety net providers throughout Oregon is working on a detailed policy and procedure manual to ensure the program's successful implementation.

The Oregon Primary Care Association (OPCA) is a non-profit corporation whose mission is to promote improved health and health care for the people and communities of Oregon. OPCA

[*] The summary of the Public meetings is located at *www.ohppr.org/hrsa/index_hrsa.htm*.

assures the availability of quality primary care, preventive services and clinicians and works to improve accessibility and utilization of health services. OPCA developed an Access Gaps Committee in December of 2000 to create a statewide picture of the gaps in access to primary health care services and to develop strategies to fill in the identified gaps.*

Oregon Community Health Information Network (OCHIN) selected Epic Systems Corporation as its strategic information systems partner and is currently finalizing a contract for buying and installing Epic's Practice Management System in Oregon's Community Health Centers. This will be done Clinic by Clinic throughout 2002. OCHIN anticipates that 10 organizations will be included in the initial phase of the implementation. Other safety net clinics have expressed interest in participating eventually in the practice management system. After implementation of the practice management system, OCHIN will begin:

- The Data Warehouse Project in conjunction with the Health Services Cluster
- An electronic medical record project
- An electronic health project to create online eligibility, electronic billing,
- Other appropriate improvements to Oregon's health safety net infrastructure.

These and other efforts are further preparing safety net clinics for CHIP Too and paving the way for improved access to health care for Oregon's children.

4.18 Which policy options were not selected? What were the major political and policy considerations that worked in favor of, or against, each choice. What were the primary factors that ultimately led to the rejection of these approaches (e.g., cost, administrative burden, federal restrictions, constituency/provider concerns)?

OHP (Insurance Coverage Model)

The following options were not selected:

- Tax credits for either employees or employers
- 1931 Medicaid
- Orthodox Medicaid expansion
- Private market individual coverage
- Individual mandates

The major considerations working in favor or against each option (and the deciding factors) were:

Tax credits:

- In favor were the direct impact on equity and the direct connection with the family/business budgeting process.
- Against were the difficulties associated with refundable tax credits for individuals and the administrative complexity of tax credits for both individuals and employers.

* See the Oregon Primary Care Association Web site for more information *www.orpca.org*.

- Deciding factors were political resistance and administrative complexity

1931 Medicaid:

- In favor were the absence of a waiver application process and the availability of budget or enrollment caps to assure that program costs would not outstrip available resources.
- Against was the fact that this approach cannot by definition include non-categorical adults and would not permit the necessary flexibility on benefits.
- Deciding factors were the exclusion of non-categorical adults from eligibility and the inability to provide flexibility on benefits.

Orthodox Medicaid expansion:

- In favor was the streamlined nature of the process (no waivers and no significant changes in eligible populations except regarding income).
- Against were the perversions and limitations inherent in Title XIX that took Oregon to the brink of health care meltdown in the late 1980s.
- Deciding factor was a compelling desire not to return to the 1980s.

Private market individual coverage:

- In favor was the fact that FHIAP currently subsidizes individual insurance with high enrollee satisfaction with the coverage thus obtained.
- Against was the fact that commercial carriers feared that a substantial increase in subsidies for individual insurance would cause a large enough increase in OMIP enrollment to require sufficiently large across-the-board premium increases that purchasers would be unhappy. Also, the cost of individual insurance creates concerns about the value of this option for those without group coverage available.
- Deciding factor was the likelihood that commercial insurers would not participate and if they did the price to the state would be too high.

Individual mandate:

- In favor was the increased likelihood that (nearly) all children could be insured and that fewer Oregonians would draw down health care resources without having contributed prior to the onset of illness.
- Against was the political liability that mandates are unpalatable except when the case for the common good is clear and compelling.
- Deciding factor was the political resistance certain to be met.

CHIP Too (Access Model)

Oregon chose to pursue CHIP Too, an alternative and complementary coverage option for children. This coverage strategy is a new approach to serving children who are difficult to enroll in public insurance. CHIP Too is a limited approach to offer primary care and preventive

services to just children, not adults. Oregon did not choose to include coverage for secondary care and will continue to rely on retroactive enrollment at hospitals for inpatient care. After CHIP Too is implemented and evaluated, Oregon may consider if incrementally expanding this model to other populations is a feasible and effective option.

4.19 How will your State address the eligible but unenrolled in existing programs? Describe your State's efforts to increase enrollment (e.g., outreach and enrollment simplifications). Describe efforts to collaborate with partners at the county and municipal levels.

OHP2 (Insurance Coverage Model)

OHP2 will allow more of Oregon's children and adults to qualify for insurance. Due to the passage of HB 2519 and the DHS reorganization efforts, the specifics of outreach and enrollment simplification have not yet been determined in regard to OHP2. In order to increase enrollment, DHS branch offices throughout the state will continue to provide public insurance information and eligibility screening. Additionally, DHS has one hundred forty outreach facilities, which include hospitals, County Health Departments and safety net clinics, who will be educated and updated about the OHP2 so that they can help Oregonians apply and enroll. Due to FHIAP's experience working with the private market, OHP2 outreach efforts will likely take on aspects of FHIAP's marketing strategies.

The Oregon Primary Care Association (OPCA) leads several projects designed to increase OHP2 awareness and enrollment for children and pregnant women. OPCA is working with out-stationed eligibility workers, local and statewide media, the DHS Health Services Cluster, and community partners on outreach efforts targeted to reduce or eliminate barriers to health insurance access. OPCA's Street Teams is a public awareness campaign encouraging and assisting in the enrollment of public insurance. OPCA, FQHCs and AmericaCorps work with local school districts to increase awareness and enrollment of OHP2.

CHIP Too (Access Model)

In order for children eligible for OHP2 but not enrolled to receive quality and continuous services, Oregon has created CHIP Too, a modified coverage option providing an additional OHP2 enrollment strategy. CHIP Too is available when the parents/guardians of OHP2 eligible children do not expeditiously enroll their children in the OHP2 program. Oregon recently submitted an 1115 waiver request asking to use a portion of its annual SCHIP allocation to directly fund health services received at qualified safety net clinics for uninsured children who are eligible but not yet enrolled in SCHIP.

Safety net providers have outreach and marketing strategies as part of their services to the communities they serve, but because CHIP Too strives to encourage OHP2 enrollment, outreach efforts will focus on OHP2 not CHIP Too. To minimize administrative burden, safety net patients will complete a simple CHIP Too self-declaration form. The form will include information about income and family size. Eligibility will be determined immediately at the safety net clinic. This simplified CHIP Too process will be similar to that used by Oregon's Family Expansion Program. A work group consisting of diverse stakeholders (including local

and state government officials, advocates, and representatives from private not for profit clinics) will determine the specifics of the simplified CHIP Too process.

CHIP Too acknowledges that insurance is not innately valued or understood by all Oregonians and therefore provides additional support and education to convey the importance of coverage to parents/guardians of low-income children. CHIP Too provides primary care to uninsured children until parents enroll them in OHP2. CHIP Too directs money to qualified safety nets providing primary health care and preventive services to uninsured children who are eligible for, but not enrolled in existing public insurance programs. Participating safety net clinics will provide information, enrollment assistance, and eligibility screening for OHP2. The safety net providers will stress the importance of enrolling in and appropriately using health insurance to their patients. The proposed CHIP Too program will *not* replace the OHP2 insurance coverage model; it will compliment and encourage OHP coverage. If CHIP too demonstrates success, Oregon may consider adopting this access-oriented coverage model to cover secondary care for children and eventually including adults.

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Section 5:

Consensus Building Strategies

5.1 What was the governance structure used in the planning process and how effective was it as a decision making structure? How were key State agencies identified and involved? How were key constituencies (e.g., providers, employers, and advocacy groups) incorporated into the governance design? How were key State officials in the executive and legislative branches involved in the process?

OHP2 (Insurance Coverage Model)

Consensus building in Oregon is complex and dynamic. Oregon is proud of the progress made during the last two decades in health care, much of it due to the ability of key leaders in the state to build consensus about the importance of universal access, the tough choices involved and the positive role private and public stakeholders can play. As political, health care, consumer and business environments change, it is important to note that the effectiveness of consensus strategies vary from one era to another era.

The Oregon Health Plan was created in the late 1980s because of a unique set of political, health care, consumer and business circumstances. Leaders emerged in each sector who were able to forge consensus within their own sector and across other sectors. The advent of term limits has made consensus building difficult in the Oregon Legislature. Only a small number of current Oregon legislators were in office when the Oregon Health Plan was created. During the next legislative session there will be no legislators from that era in office if term limits remain.

Turnover in the health care industry is substantial. The average business tenure of a hospital CEO, an insurance plan CEO, and an HMO medical director is all less than five years. Substantial changes have occurred in Oregon business as high tech firms have flourished and traditional Oregon industries have declined. The downturn in the nation's economy appears to be more pronounced in Oregon than in other states. Consumer organizations have changed as issues have evolved and other interests have influenced them. Despite these changes Oregon has been able to keep consensus building regarding universal access at the top of its priority list.

Oregon's Legislature meets every two years. As a result Oregon moves through a biennial decision cycle that begins at the end of each legislative session. The 1999 Legislative session was a difficult session for the Oregon Health Plan. Consensus was not reached between executive and legislative branches. Legislation changing OHP was passed by the Legislature and eventually vetoed by the Governor. Both Governor Kitzhaber and the Legislature were frustrated by their inability to change benefits based on the prioritized list as a result of HCFA (CMS) policy. No agreement was reached on tobacco settlement funds resulting in accumulation of the funds in trust. The OHP budget was approved at a maintenance level with moderate increases for providers. Providers however were concerned that such increases in the past had not been

distributed equitably and no policy change had been made to ensure that would happen in the future.

In Fall 1999 the Health Services Commission, the public body responsible for the prioritized list, decided to organize Spring 2000 meetings to seek public input on the future of the Oregon Health Plan. The Oregon Health Council, the public body responsible for advising the Governor on health issues, agreed on the need for public discussion regarding the Plan. In January of 2000 the Health Resources Commission, the public body charged with assessment of health technologies, decided to focus on prescription drug issues.

In January 2000 Governor Kitzhaber outlined his priorities for the Plan in his "State of the State" speech. His commitment to universal access was reemphasized. He made his interest in pursuing benefits flexibility clear. Prescription drugs were identified as an issue of key cost and quality importance. He urged a renewal of public/private efforts to solve the problems of the Oregon Health Plan.

Sixteen public meetings were held in Spring 2000 to gather public input on the Plan. Over one thousand Oregonians of diverse backgrounds participated. Oregon Health Decisions collected quantitative and qualitative data on the sessions. A telephone survey of more than 700 Oregonians was also conducted to assess the public's sense of the Plan. The Office for Oregon Health Policy and Research (OHPR) distributed a report on the sessions. A summary of key Oregon Health Plan data was distributed to Legislators.

In September 2000 Governor Kitzhaber convened a Health Summit in Eugene, Oregon. More than 450 invited participants from all sectors of the health care industry attended, from all parts of the state and all segments of the population. Four panels reported on key issues—prescription drugs, benefit approaches, delivery system approaches and financing issues. Governor Kitzhaber provided an assessment of the current plan and his suggestions for reform, raised concerns that the Oregon Health Plan was in the midst of a significant crisis, and emphasized the importance of a return to the basic principles driving the Plan. The Governor committed to a statewide effort to reach consensus on "saving the Oregon Health Plan".

HRSA awarded Oregon funds to plan for strategies to pursue universal coverage in late September. Governance for this planning effort was designed to complement many other OHP groups working on strategy and design issues. Mark Gibson, the Governor's chief policy advisor for health and human services chaired the Governing Body. Members of the body included administrators of the key state agencies providing health services, and representatives of key private stakeholders—business, labor, consumers, physicians and hospitals. All state agencies involved in the Oregon Health Plan were represented. This group met monthly with reasonable attendance and participation. Given the success of our efforts it has been a useful mechanism for discussion and direction regarding strategic options. Many individuals involved in the Governing Body have played key roles in the progress of OHP proposals.

Supporting the Governing Body have been two panels—Technical and Policy experts and Community Partners. The Technical and Policy expert panel was composed of key state managers familiar with health care issues and private stakeholders interested in similar issues. Participation was not as broad as hoped but those who participated did so consistently and

provided substantial amounts of information and assistance in reaching the goals of the project. The biggest challenge for the Technical and Policy panel was competing with other priorities for time and interest. This was made more difficult during the Legislative session when virtually all resources were devoted first to legislative issues.

The Community Partner panel was not as successful. The HRSA Team was unable to successfully define the role of the Community Partner panel in the context of legislative and health policy activities. The legislative session, which ran from January–July 2001, made this effort even more difficult. Most community participants have limited resources for such activities. When the Legislature is in session their resources are focused on the session. Competing activities and the uncertain role that this panel would play contributed to its lack of success.

The HRSA planning effort was successful in involving State officials and executive branch officials but has struggled to involve legislators. Legislators have significant limits on their ability to participate in such activities. Oregon legislators are citizen legislators, compensated during the legislative session and for specific activities during the eighteen month "interim". Legislators are provided resources for staff during session but not during the interim. All resources during session are devoted to the session itself for good reason.

The typical legislative session in Oregon lasts six months and is marked by intense work throughout. Interim staff resources are limited to full-time staff engaged in fiscal, revenue, judicial and interim committee activities. Full time staff exist in each chamber for each party but the number of issues these staff work on is large and requires significant prioritization. Legislative staff frequently raised concerns that their efforts, by necessity, had to be focused on issues specifically directed from the 1999 Legislature, efforts having an immediate effect during the interim, and organizational efforts in preparation for the 2001 session.

Concerns were raised that provision of any funds to legislative staff for salary or expense would violate the separation of executive and legislative branches. The HRSA Grant initially proposed to bridge this gap by hiring a "legislative liaison" to focus solely on the legislature. Several individuals were recruited and interviewed for this position. During this process there was consistent feedback that such a strategy would be seen as lobbying by legislators and might have the reverse effect desired. Ultimately the grant proceeded with minimal legislative involvement. This is clearly an area for improvement if done again. In retrospect both the Community Partner effort and legislative involvement were made much more difficult due to the occurrence of the 2001 Legislative session during the grant period.

The HRSA effort was only one of many efforts that were pursued to reach consensus. Governor Kitzhaber met with hundreds of physicians and physician leaders throughout the state during fall of 2000 and winter of 2001. These meetings and subsequent involvement of physicians at multiple levels of discussion and decision-making were integral in enlisting consistent and persistent support among physicians for the Plan. Likewise the Governor met with hospital leaders throughout Oregon. In particular he urged their support of the community oriented Medicaid-only plans that have emerged in their communities. Hospitals played a stabilizing role in key communities. Health plans were also included in multiple discussions as the larger plans

considered withdrawal from the Oregon Health Plan. Agreements were reached allowing an orderly withdrawal of major insurers, which also contributed to stabilizing the Plan.

Consumer and public participation in the process was promoted in a number of ways. The key public bodies of the Oregon Health Plan met on a regular basis throughout the fall and winter taking on key issues involving the Plan. The Health Services Commission focused on benefits issues, the Health Resources Commission on prescription drugs, and the Oregon Health Council on a variety of related issues, including the delivery system. Governor Kitzhaber organized several additional workgroups on key issues. A diverse group of policy experts developed a set of key principles to reform the OHP. A second set of stakeholders, including legislators, was organized to reach consensus on key issues during the Legislative session. State agency officials and the Governor's staff met often with key stakeholder groups OHP carriers, OHP medical directors, advocacy groups, consumer groups, brokers, agents, businesses, purchasers. A similar process was maintained for issues around prescription drugs—an issue of equal importance and controversy for the Governor and state officials.

A series of public meetings are currently underway focused on benefits trade-offs.[*] The Health Services Commission, Health Resources Commission, and Oregon Health Council are all preparing for a busy fall and winter focused on the OHP.

House Bill 2519, passed at the end of the 2001 Legislative Session, established a decision-making framework for OHP reform and expansion in four parts of state government:

- The Office of Oregon Health Plan Policy and Research will support the work of the Health Services Commission in design of the benefit plan for the newly created OHP Standard plan.
- The Department of Human Services will oversee the Waiver Application Steering Committee. This Committee will monitor the waiver efforts authorized by the legislation including the designation of the benefit level.
- The Department of Consumer and Business Services will oversee the Insurance Pool Governing Board and its Health Insurance Reform Advisory Committee as it designs private benefit packages to be subsidized by the Oregon Health Plan.
- The Legislature will oversee the entire effort via the Legislative Leadership Commission on Health Care Costs and Trends.

Efforts are underway to initiate and coordinate these four efforts. Stakeholders and government are involved in these efforts, in some cases at multiple levels. We have come full cycle and in many respects turned around the concerns that were raised two years ago. Much of this is due to the multiple consensus strategies pursued.

[*] See Public Meeting Summary at *www.ohppr.org/hrsa/index_hrsa.htm*.

CHIP Too (Access Model)

Multiple state agencies,* including the Oregon Health Division, the Office of Medical Assistance Plans and the Office of Oregon Health Plan Policy and Research, have been involved in the decision-making process though no single state agency is entirely responsible for the safety net, a concern raised by safety net organizations. The Department of Human Services is currently evaluating a more focused approach that would relate to safety nets. The Oregon Health Division has in particular taken the lead in helping to organize the safety net effort and the CHIP Too waiver request. Much of this work has been done by staff familiar with both Medicaid and the Health Division, suggesting the benefits of a single "organizational home" for safety nets. Safety net and consumer advocates are represented in all decision-making bodies affecting the Oregon Health Plan.

The CHIP Too proposal emerged as a recommendation from the Oregon Health Council and is part of a series of successful collaborative activities. Safety net clinics, CareOregon, and other public and private stakeholders have been able to collaborate to form Oregon Community Health Information Network (OCHIN) and compete successfully for funds to organize information systems. CareOregon, the state's largest Medicaid-only HMO, has successfully integrated safety net clinics in its OHP delivery system and provided organizational and financial resources to safety net clinics. Communities in Charge, a program funded by the Robert Wood Johnson Foundation, provides a forum for safety net operations in the Portland tri-county area to organize strategies for universal access at community levels. These efforts all contributed to a more organized and unified voice for safety net clinics to state agencies, the legislature and the Governor's Office.

Safety net clinics have emphasized their willingness to provide more accountability and predictability. They have demonstrated an ability to develop local funding streams from counties, school districts and other sources. This work was underway prior to the HRSA grant although the grant has provided an important opportunity for safety net advocates and government agencies to refine and further develop ideas. Safety net advocates formed the Safety Net Coalition. This broad based group of advocates has become a critical mechanism for state and advocate collaboration and planning. It will be an important vehicle in the future in this same role.

5.2 What methods were used to obtain input from the public and key constituencies (e.g. town hall meetings, policy forums, focus groups, or citizen surveys)?

OHP2 (Insurance Coverage Model)

Multiple methods have been used to obtain input. These include:

- Public forums in multiple locations in 2000 and 2001
- Stakeholder meetings with diverse groups throughout the state

* The 2001 Oregon Legislature authorized reorganization of the Department of Human Services (DHS). The new DHS Cluster includes these former separate agencies: Oregon Health Division, Office for Medical Assistance Programs, Alcohol and Drug Abuse Programs, and the mental health functions of Mental Health and Developmental Disability Services Division. This report will refer to agencies as they were prior to the reorganization. Additional information about the DHS reorganization can be found at *www.hr.state.or.us/dhrinfo/future/org-proposed.html*.

- Governor presentations to multiple stakeholder groups throughout the last two years
- Governor's Health Summit in September of 2000
- Monthly meetings of health policy experts in Portland and Salem
- Telephone survey in 2000 and 2001; focus group studies in 2001; FHIAP study in 2001
- Multiple public commission meetings on a monthly basis
- Regular notices of events to Office of Oregon Health Plan Policy and Research email and mailing lists
- Participation in multiple conferences and community events by state officials
- Web sites for HRSA, OHPR, Office of Medical Assistance Programs
- Multiple meetings with agents and brokers
- Multiple meetings with legislators by state officials and Governor
- Participation in multiple groups pursuing universal access strategies

CHIP Too (Access Model)

Safety net providers, state officials, local officials and patient advocates are actively involved in all CHIP Too efforts, hoping the efforts will lead to further involvement with rural safety net clinics, OHP carriers and others. The plan is to conduct key informant interviews, focus groups and stakeholder meetings in early 2002. An advisory committee is currently forming to determine operational specifics of CHIP Too pending waiver approval. The advisory committee will include FQHCs, rural health centers, school based health centers, county health departments, freestanding clinics and advocacy groups. The committee will work on eligibility process issues in hopes of increasing coverage. The committee will also work on streamlining claims, billing and information processes. The impetus for CHIP Too has come from consumer and safety net organizations that introduced the idea in the Oregon Health Council.

The Spring 2000 public meetings sponsored by the Office of Oregon Health Policy and Research identified access problems, especially for the eligible but not enrolled, as significant concerns. During these meeting it was not unusual to hear concerns expressed that having health plan benefits was irrelevant if there was no access to services for rural, ethnic and other populations.

The Oregon Health Council responded to these concerns through the resolution process.[*] The Council meets in public sessions and continues to express consistent concerns regarding these issues.

[*] See Safety Net Resolution. Salem, OR: Oregon Health Council; March 2001. *www.ohppr.state.or.us*.

5.3 What other activities were conducted to build public awareness and support (e.g., advertising, brochures, Web site development)?

OHP2 (Insurance Coverage Model)

Other activities have included:

- Web sites have been developed although these have been difficult to coordinate and keep current.
- Multiple press releases have been coordinated with public meetings throughout the state resulting in substantial media coverage.
- Several stakeholders have produced papers and/or proposals regarding the OHP and distributed these.
- HMO carriers developed a brochure regarding OHP and distributed it widely.
- Providence Health System developed and funded an advertising campaign supporting the OHP.
- FHIAP, OMIP and IPGB have communicated to their members, agents, brokers, carriers and others the potential changes in their approach.

CHIP Too (Access Model)

Oregon hopes that the attention and resources devoted to CHIP Too will result in more interest in this alternative strategy from a variety of sectors. CHIP Too will be an effective outreach strategy for eventual OHP coverage, providing a "bridge" at a time when parents are most likely to consider coverage for their children. Oregon will be able to promote coverage and provide key health services to the uninsured at the same time. This demonstration will provide another forum for safety nets and the population they serve to work with the state to provide more organized and comprehensive services.

Safety net providers and CareOregon have devoted considerable time and resource to development of this option. The Communities in Charge program has held multiple community forums, focus groups and stakeholder meetings to discuss similar approaches.

5.4 How has this planning effort affected the policy environment? Describe the current policy environment in the state and the likelihood that the coverage expansion proposals will be undertaken in full.

OHP2 (Insurance Coverage Model)

The HRSA grant has added to the volume and credibility of Oregon's policy work around universal coverage. While Oregon has been an incubator for a variety of ideas during the last two decades much has been learned from other states. The planning grant has provided resources to help Oregon evaluate its ideas. While the timing was a challenge because of the Legislative session it also provided a great opportunity and a fertile environment for the HRSA grant. Much of the work done has been crucial in helping to focus decision makers and overcome key obstacles (benefit analysis, cost-sharing analysis, FHIAP study). The comprehensive nature of

the grant has allowed analysis of multiple models and development of two major strategies. Much of the information is yet to be "discovered" by policy makers. This will likely occur as the issues around the waiver request and implementation "ripen".

Oregon's planning effort has contributed to the return of universal access to the forefront of the Oregon debate. The planning grant has enabled Oregon to discuss ideas with other states and with federal officials, external to the waiver process and the political context. This has been valuable in refining ideas and getting a sense of the concerns policymakers may have from a distance.

The planning grant has significantly increased the health policy experience of a number of individuals. Oregon has increased the number of knowledgeable individuals within the state, an investment that will bear fruit for many years to come. Many of these individuals will move to key planning and policy positions. For example, Lydia Lissman, the project's director for the first eight months, moved to the position of administrator of the state's Senior and Disabled Services Division.

Oregon is in the midst of organizing the work required for waivers related to House Bill 2519, hoping to submit this waiver in early 2002 and believing it will be approved in some form. Previous experience has taught that the waiver process is a negotiation and compromise process for good reason. Two governments are attempting to reconcile different philosophies, cultures and laws. A reasonable outcome is anticipated to these negotiations and eventual implementation that will carry Oregon several steps further toward universal access.

CHIP Too (Access Model)

The success of the organized safety net efforts have improved the credibility of the safety net system, resulting in improved funding from the Legislature, and likely a more organized approach by state agencies to safety nets. The success of CareOregon has led to more interest on the part of OHP carriers to integrate safety net operations into their delivery systems. The willingness of school based health clinics to participate in more accountable and predictable efforts will enhance their credibility and stabilize funding for them. State and local funds are available to provide state match if the waiver is approved. Safety net organizations have become reliable participants in the policymaking process.

CHIP Too stands a good chance of being approved. This is, in part, due to a new administration at the federal level headed by Tommy Thompson, a former governor. The Bush administration has indicated it would be flexible in approving waivers. In addition President Bush has committed the administration to addition funds for community health center sites. This will strengthen the safety net and provides a good complement to Oregon's strategies. Oregon believes that even if, for some reason the CHIP Too waiver is not approved it will be possible to implement a very similar approach through the Title 19 Medicaid program.

CHIP Too is a first step, a demonstration, that Oregon can construct complementary coverage and access models. If successful this first step can lead to additional communities, safety nets and OHP carriers following the early adopters. This approach could work eventually for adults and could eventually include specialty physician and outpatient services. The focus is now on demonstrating that we can be successful with this first significant step.

Section 6

Lessons Learned and Recommendations to States

6.1 How important was state-specific data to the decision-making process? Did more detailed information on uninsurance within specific subgroups of the state population help identify or clarify the most appropriate coverage expansion alternatives? How important was the qualitative research in identifying stakeholder issues and facilitating program design?

How important was state-specific data to the decision-making process?

State-specific data were extremely important, allowing Oregon to use multiple data sources to create a coherent picture of Oregon's health care needs and to craft viable options. State-specific data sources included:

- ***Actuarial data***, which allowed comparison of current Oregon Health Plan (OHP) benefits to standard benefit packages for:
  - The Family Health Insurance Assistance Program (FHIAP)
  - Mandated Medicaid programs
  - State employees
  - Typical commercial plans

  This information—specific to Oregon—helped shape discussions about appropriate benefit levels for expansion populations. The actuarial data enabled Oregon to move from anecdote to state-specific data.

- ***The FHIAP Study*** helped quantify FHIAP's impact on Oregon families. This research confirmed the program's popularity, provided information about the best way to structure subsidies and gave insight into ways to increase enrollment. It also allowed better understanding of the needs of those waiting to enroll in FHIAP. For example, people on FHIAP's Reservation List are very similar to uninsured individuals awaiting access to Medicaid and many are at risk for significant health problems. The FHIAP study provides data relevant to the low-income employed population—such approaches result in significant improvements and are highly valued.

- ***The Oregon Population Survey 2000 (OPS)***, discussed in detail in Section 1 of this report, provided the most accurate and detailed source of information about the uninsured in Oregon. In particular, county-level data are helpful in demonstrating the impact of uninsurance to legislators and local decision makers.

- The Oregon-specific ***1998 Medical Expenditure Plan Survey (Insurance Component)***, discussed in Sections 1 and 2 of this report, was a principle data source about employer-sponsored health insurance. In addition to MEPS data published by the Census Bureau, the HRSA Team also analyzed MEPS data generated for the Agency for Healthcare Research and Quality (Special Run MEPS).

- The statewide ***Household Survey*** provided key information about the relative importance of health care issues compared to other issues facing Oregonians, household experience in seeking health care, core values driving health care discussions, and support for various health insurance expansion and cost reduction options.

- ***Focus groups*** played an important role in our research and are discussed below in relation to the importance of qualitative research.

- ***Continuity and Turbulence in an Expanded Medicaid Managed Care Program, The Oregon Health Plan Experience***, a study funded by the Center for Health Care Strategies through a grant from the Robert Wood Johnson Foundation, examined continuity and turnover within the OHP.[, 2001 #203] Among its major findings include identification of churning as a significant problem for the OHP; 38% of OHP clients leave the program before a year has elapsed.

Did more detailed information on uninsurance within specific subgroups of the State population help identify or clarify the most appropriate coverage expansion alternatives?

Yes. Section 1 of this report summarizes the findings, but in general, research on the uninsured in Oregon pointed to the need to:

- Improve safety net options (a large number of people eligible for OHP remain uninsured, and a significant number prefer to use safety net clinics even if insured);

- Reach more children by expanding CHIP and offering simplified eligibility to low-income children at safety net clinics through implementation of CHIP Too;

- Expand eligibility to 200% of the Federal Poverty Level (FPL) for all adults, although budget constraints have limited the expansion coverage to 185% of the FPL;

- Find ways to increase the number of low-income individuals who receive health insurance via their employer such as through use of premium assistance programs;

- Consider portability options; more than half of all uninsured are without insurance for less than 12 months;

- Develop strategies to provide health care to a higher proportion of racial and ethnic minority populations as well as other underserved populations, e.g., implementing CHIP Too, improving outreach; targeting appropriate employers; public education about the value of health insurance; clarifying eligibility in relation to existing immigration law.

- Concentrate on rural communities using multiple approaches—such as improving outreach to employers, agents/brokers, and health care providers.

How important was the qualitative research in identifying stakeholder issues and facilitating program design?

The qualitative research (focus groups with uninsured Oregonians, small employers, providers and health care administrators) played an important role. In general, much of this terrain had already been explored, but individual voices and their stories give powerful, present-tense meaning to abstract numbers. Local, state and federal decision makers need to hear such stories. The qualitative research was also very useful in identifying issues such as cost-sharing challenges among low-income Oregonians, especially Hispanic and rural populations.[*]

In addition to focus groups, the HRSA Team worked with the Health Services Commission to organize a series of public meetings around the state to discuss cost-sharing tradeoffs and benefit priorities. The meetings indicated support for the general strategy of funding expansion through a reduction of benefits to certain groups.[†]

6.2 Which of the data collection activities were most effective relative to resources expended in conducting the work?

Perhaps the most effective data collection strategy was the appropriate use of secondary research. The HRSA Team (and we suspect this is true of all the HRSA-funded sites) sifted through hundreds of studies and policy documents. In addition the team met with national experts, with state and community leaders in Oregon, and leaders from around the United States. There is no faster way to generate or reject options.

Looking at Oregon's original research, the four most effective data collection activities were:

- Actuarial Analysis
- Analysis of 2000 Oregon Population Survey
- FHIAP Study
- Public meetings

6.3 What (if any) data collection activities were originally proposed or contemplated that were not conducted? What were the reasons (e.g., excessive cost or methodological difficulties)?

Panel/Cohort Study: Oregon had proposed a series of four telephone surveys and two rounds of focus group sessions conducted over a seven-month period. The same group of respondents would have taken part in all four telephone surveys. A sub-sample of this group would have been recruited to take part in the focus group sessions. The study was imagined as a way to track

[*] Section 1 of this report contains detailed information about the focus group research; For the complete summary of the Focus Group Study, see *www.ohppr.org/hrsa.org/hrsa_htm.*

[†] For the summary of the Public Meetings, *www.ohppr.org/hrsa.org/hrsa_htm.*

opinions about options under consideration for achieving universal health coverage as those options evolved. This study was not conducted. When it was put out to bid no contractors were willing to take on the study. It was decided that the project as originally conceived was too large and too costly given available resources to complete in such a short time frame.

6.4 What strategies were effective in improving data collection? How did they make a difference (e.g., increasing response rate)?

The Oregon Population Survey (OPS) researchers conducted sample extensions to increase sample sizes for members of four ethnic/racial groups: African Americans, Asian Americans, Native Americans and Hispanics. This strategy allowed for more accurate estimates of uninsured rates for these target groups. In addition researchers stratified the sample by nine regions of the state and collected data from at least 400 households within each region. By this means meaningful sub-area comparisons and minimize sampling variance could be made.

The FHIAP research team completed two related surveys of FHIAP enrollees and FHIAP reservation list individuals.[*] The surveys were administered by mail achieving a 72% response rate for the enrollee group and 55% for the reservation list group. A number of strategies were used to attain these results, including:

- ***Use of cognitive testing to finalize questionnaires***—Fifty FHIAP enrollees were chosen at random, told about the project and offered $20 to complete a pretest version of the questionnaire with a member of the research team present. Fifteen enrollees agreed. During the pretest session, enrollees were asked to fill out the questionnaire by themselves, then, question-by-question, they reviewed their responses with the researchers. As a result, the questionnaire was improved, the quality of information was enhanced and the response rate was boosted
- ***Close collaboration with FHIAP Staff***—The HRSA Team contracted with an independent research firm to conduct the FHIAP Study, but also worked closely with FHIAP administrative staff. The Team publicized the study, sent an announcement on FHIAP letterhead and offered FHIAP's hotline number to anyone who wanted to contact FHIAP directly.
- ***Use of three-wave mail-return protocol***—One week after sending the initial mail survey a reminder postcard was sent. If there was no response, two weeks later a replacement survey was sent.

6.5 What additional data collection activities are needed and why? What questions of significant policy relevance were left unanswered by the research conducted under the HRSA grant? Does the State have plans to conduct that research?

While Oregon made significant progress via the HRSA grant, there is a need for additional data collection activities. Examples include the need to learn more about cost-sharing, about changes in utilization patterns that may be caused by changes in benefit design and about service delivery

[*] For the complete FHIAP study results, see *www.ohppr.org/hrsa.org/hrsa_htm.*

issues, especially workforce/capacity issues, created by an increase in the number of OHP participants. While the state may not be in a position to directly initiate data collection in all these areas, Oregon certainly has a role. Additional data collection activities would assist decision makers in understanding the difficult tradeoffs that arise from chosen strategies.

To date we have identified six projects that will add data to Oregon's planning efforts, and if Oregon is successful in its waiver efforts other research projects will be initiated:

- ***Additional Actuarial Research***—Currently Oregon is applying actuarial models to an adult FHIAP population in order to develop a commercial benchmark standard. This work should be completed by November 2001.

- ***Employer study***—As ways to expand FHIAP are considered, additional information is needed about employer contribution levels, benefit offerings and willingness to work with the state to expand the employee-subsidy program.

  The HRSA Team has initiated work on a case study of employers with high offer rates but low take-up rates. This work will support a statewide survey of employers that will help determine the best ways to increase FHIAP's enrollment via the group market.

- ***Study of Linkages between Safety Net Clinics and OHP Carriers***—Even after expansion of OHP, some Oregonians will still be without health insurance. For those Oregonians the HRSA Team designed a complementary health coverage strategy, the Access Model. It is tailored to meet the needs of those eligible-but-not-enrolled in public insurance and those who move on and off of public insurance. The Access Model will facilitate enrollment of eligible Oregonians in the OHP, but also acknowledges that some people do not value or believe they need insurance.

  The HRSA Team will interview local providers, hospitals, specialists, and safety net clinics throughout Oregon to determine community willingness and capacity to adopt an alternative coverage strategy like the Access Model for the remaining uninsured. In addition, this information will support Oregon's proposed CHIP Too program, which is designed to use a portion of CHIP funding to provide primary care health services to uninsured children seen at safety net clinics.

- ***Analysis of Cost-Sharing in a State-Sponsored Health Insurance Program***—Oregon plans to conduct a study in conjunction with Washington's Basic Health Plan and the Yakima Valley Farm Workers Clinic, a large safety net organization operating in both Washington and Oregon. Washington operates a plan somewhat like Oregon's FHIAP, covering 280,000 Washington residents some of whom participate in cost-sharing. This population includes individuals who receive care through a safety net organization as well as those who are enrolled with a variety of carriers and includes both Washington and Oregon residents. The analysis of data from a significant sample of similar Oregon and Washington populations engaged in cost-sharing would help to clarify how cost-sharing is handled by low-income individuals and provide additional guidance for implementing the decision of Oregon's Legislature.

- ***A Ten Year Analysis of Oregon's High Risk Pool (Oregon Medical Insurance Pool, (OMIP)***—Oregon's high risk pool has covered more than 29,000 individuals in the last ten years. However, concerns exist about OMIP's future, the stability of the individual market and the appropriate role of public subsidies in that market. Currently, OMIP is funded through purchase of coverage by individuals, by employers, and by assessments on insurers based on an insurer's total market share. While OMIP has been a key stabilizer of the individual market, insurers have expressed concerns about possible increases in their OMIP assessments. Since assessments are based on the number of OMIP enrollees, FHIAP subsidies to high-risk individuals would increase the pool and, under the current system, increase assessments. In addition, the rejection rates in the individual market have recently doubled.

  All these factors suggest the need to know more about the high-risk pool. Identifying the source of increased enrollment will be particularly important in creating strategies to stabilize OMIP and the individual market. Oregon also expects to analyze trends in rates and utilization over OMIP's ten-year history.

- ***Portability Options***—Since many low-income Oregonians have temporary lapses in insurance, Oregon would like to explore how to create 'bridge' coverage (for example, via an expansion of Transitional Medicaid or by subsidizing portability insurance).

6.6 What organizational or operational lessons were learned during the course of the grant? Has the State proposed changes in the structure of health care programs or their coordination as a result of the HRSA planning effort?

What organizational or operational lessons were learned during the course of the grant?

Strategies for health care reform can be incremental or broad based. Current political, market and resource constraints make broad based reform unlikely. Expanding health care coverage competes with other health issues including mental health reform, broad based social needs of children, the need for improved reimbursement for current providers, and access problems. The issue of access was raised consistently in coverage discussions. In many areas of Oregon the number of providers and/or willingness of providers to see Medicaid patients took precedence over discussion of strategies to expand coverage. Oregon believes that such complexity is best managed by careful incremental change.

Multiple forces interact with coverage and access strategies. The overall economy of the state has a critical influence on employer financing and government financing of health care. The competition for workforce has a major impact on the provision of health benefit plans by employers. A variety of factors impact workforce issues for health care providers. These forces may have little or nothing to do with universal coverage or even health care in general. Universal coverage strategies need to be flexible enough to respond in some way to these forces.

Previous attempts at reform need careful and honest evaluation. Oregon's attempts at an employer mandate, for example, failed for very specific reasons. The circumstances leading to this outcome remain. No resources were expended pursuing this option. Oregon's prioritized list

resulted in significant savings initially and was limited eventually by federal concerns. Analysis reveals that the Prioritized List continues to be the source of significant savings, yet the prioritized list is not likely to be an acceptable mechanism for further benefit changes. The decision to retain the list but leave the level of benefits the same was made, allowing focus to shift to other benefit strategies.

Successful strategies require substantial planning, communication with multiple stakeholders and patience. The OHP2 strategy has evolved as part of almost 20 years of reforms inspired by Governor John Kitzhaber. The CHIP Too strategy is very early in its development and dissemination. Visionaries, planners, and implementers all play separate but important roles in these efforts. It is unusual for a single person to have all of the necessary perspectives, resulting in the need for effective teams to emerge. Institutional preferences are difficult to overcome leading to frequent racial, gender and other social biases. Even when hundreds of people have been involved it is almost certain that important stakeholders will have been left out.

Safety net providers need to be included in planning efforts, on many fronts and in multiple levels of conversation. Safety nets need support and encouragement to become more organized, accountable and predictable in their operations. They need to become better integrated with other safety nets and with the traditional delivery system. In order to better support the safety net and ensure that Oregon's uninsured have access to quality health care, the State is considering what support it can provide to complement efforts to organize, integrate, and strengthen Oregon's safety net. The Oregon Health Division (OHD),[*] Office for Oregon Health Policy and Research, and Oregon Medical Assistance Program (OMAP) are currently working with the safety net community to explore the idea of a State safety net office.

Multiple and persistent efforts are needed to communicate health care strategies to the stakeholders involved and to the public. Multiple forums are needed to carry this out. Public, private, formal, informal, business, legislative and consumer strategies all must be employed. A campaign emphasizing the importance and availability of insurance as well as the changes resulting from OHP2 is key to its successful implementation. A communications program that includes statewide advertising, public relations events, and grassroots community outreach are needed to assist in educating Oregonians about OHP2. The lifespan of any single effort may be limited, useful for only a limited time or a single task. When an effort is not working it needs to be discontinued and replaced by a more constructive strategy.

Connections between public and private approaches are essential but particularly challenging. Often visions and philosophies clash. Patience and persistence are needed. For example, selection of the sickest enrollees is a desired attribute of public approaches but is counter to the success of private insured approaches. When public programs work to interface with the private sector the stakes are high for all.

[*] The 2001 Oregon Legislature authorized reorganization of the Department of Human Services (DHS). The new DHS Cluster includes these former separate agencies: Oregon Health Division, Office for Medical Assistance Programs, Alcohol and Drug Abuse Programs, and the mental health functions of Mental Health and Developmental Disability Services Division. This report will refer to agencies as they were prior to the reorganization. Additional information about the DHS reorganization can be found at *www.hr.state.or.us/dhrinfo/future/org-proposed.html*.

Has the State proposed changes in the structure of health care programs or their coordination as a result of the HRSA planning effort?

The HRSA planning grant provided key resources for the development of strategies Oregon is pursuing. Work around benefits, employer-sponsored issues and access issues would be far less sophisticated without the HRSA resources. Oregon understands coverage issues far better because of these resources. Oregon also understands the need for better coordination between safety net clinics and other parts of the health care delivery system and has begun to put the ideas of public/private partnerships into action.

Safety net providers, government officials, and health care advocates nationally and throughout Oregon are examining the safety net's role in the health care delivery system. They are sharing expertise and resources to develop a strategic plan to stabilize, strengthen, and expand the safety nets' ability to provide access to quality health care to the underserved. An Oregon proposed strategy, the Access Model, would provide access to health care for the uninsured, as well as assists the safety net in stabilization and expansion efforts. The Access Model encourages and assists with enrollment in OHP2 while offering compensation to the safety net for care provided to children who are eligible for the OHP2 but not enrolled.

The Access Model would *not* replace the OHP2 insurance coverage model; it would complement it. The safety net would encourage enrollment into insurance plans through outreach, culturally appropriate education regarding private and public insurance, OHP2 eligibility screening, and assistance with the OHP2 application. For those eligible individuals who do not enroll in OHP2, the safety net could be the point of primary care access. The safety net would have formal relationships with secondary and tertiary service providers in their community to ensure comprehensive and integrated health care. Furthermore, secondary and tertiary providers could refer uninsured patients to the safety net. Safety net services provided to individuals who are eligible but not enrolled in publicly funded insurance programs would be compensated by the State, through the CHIP Too waiver. For those categorically eligible but not enrolled in OHP2, in-patient care would continue to be compensated through a Medicaid retroactive payment or "hospital hold" policy.

The Access Model, a limited and interim coverage option ensuring access to health care, would be implemented in three phases. The first phase would be implementation of the proposed CHIP Too waiver. The CHIP Too waiver proposes to financially compensate safety net clinics for health care services provided to uninsured children eligible for SCHIP who cannot or will not enroll in pubic insurance programs. The second phase would provide secondary and tertiary care to Oregon's children living in families with incomes below 185% of the FPL. The third phase of the Access Model would be the integration of primary care and preventive services for adults below 100% of the FPL. The Access Model will not replace the OHP2 insurance coverage and will be closely evaluated to ensure its effectiveness.

In order to assure accountability and quality as well as evaluate if the Access Model is an effective interim coverage option, the HRSA Team proposes that the Access Model require participating safety net providers meet criteria to become an Oregon Qualified Health Center (OQHC). An OQHC will meet standards similar to, but less stringent than, those of a Federally Qualified Health Center (FQHC). It is likely that OQHC criteria will be similar to qualified

health center standards set by Maryland, West Virginia and the District of Columbia. Oregon's Department of Human Services (DHS) recently hired someone to explore the OQHC concept.

Because of the HRSA planning effort, additional attention, time and resources were put into disseminating these ideas and related information to stakeholders. The HRSA planning effort came at a perfect time, coinciding with Governor Kitzhaber's last legislative session, with a significant transition of the Oregon Health Plan, and with multiple community efforts to understand and improve coverage and access strategies. These efforts include the Tri-Counties Communities in Charge project and the study of enrollment completed by the Center for Outcomes Research and Education (both funded by the Robert Wood Johnson Foundation). Exposure to other states was crucial to Oregon's thinking and was helpful in convincing Oregon stakeholders that many ideas were worth pursuing. The HRSA planning effort helped develop a realistic appraisal of Oregon's current situation and potential strategies.

6.7 What key lessons about your insurance market and employer community resulted from the HRSA planning effort? How have the health plans responded to the proposed expansion mechanisms? What were your key lessons in how to work most effectively with the employer community in your State?

What key lessons about your insurance market and employer community resulted from the HRSA planning effort?

Please see Section 2 of this report for a detailed description of our findings on employers, and Section 3 for a description of the health care marketplace. However, key lessons include:

Insurance Market:

- Risk selection remains a powerful force for insurance success. Selection may be a bigger issue in Medicaid than overall reimbursement levels. It is easier to be good at risk selection than managing care. Competition is a fact of life on the private side. Public programs can compete with private insurers and create another competitive playing field for them.
- Communities are suspicious of insurers regardless of profit or not-for-profit status. Communities want resources devoted to a community to stay in a community. Mergers and acquisitions raise concerns particularly as influence of local governance is lost.
- Marketing strategies work to encourage lower risk people to purchase insurance. Government programs should get better at marketing their "products."

Employer Community:

- While national data suggests employers are maintaining contribution levels, anecdotal Oregon information suggests a recent decline. Current premium increases in Oregon may be larger than the rest of the country after years of being among the lowest. As a

result employers are under a great deal of pressure and willing to entertain new cost saving approaches.

- Employer–based insurance keeps pace with demographics—the population grows, the economy grows. This is not necessarily the case with public programs.
- Employer contributions to employee health insurance vary a great deal depending on the type of firm. It is estimated that at least 25% of employers contribute 45% or less for family coverage. The overall average percent contribution is not a useful measure.
- A significant, and possibly growing, number of employees are offered ESI but refuse coverage. The cost of family coverage is an especially large burden on low-income households.
- Purchasing alliances still need to demonstrate a benefit.
- Employers tend to like employee subsidy programs if they are administratively simple and equitable.

How have the health plans responded to the proposed expansion mechanisms?

Oregon has a unique health plan delivery system that is still evolving. These changes are summarized in the *Report of the Access Subcommittee of the Oregon Health Council*.[*] Traditional commercial insurers and HMOs have largely retreated from the Medicaid market. Community-oriented Medicaid-only HMOs have emerged to take their place. Almost all of these plans are provider owned and/or dominated. Virtually all Medicaid markets with more than 5,000 enrollees have community oriented plans. Smaller Medicaid markets do not have such plans and as a result have experienced even more turbulence than the Medicaid market as a whole.

Health plans, both Medicaid and traditional, have expressed concern and interest about proposed coverage expansion strategies. Selection, reimbursement, crowdout, competition, and administrative complexity have emerged as important issues.

Medicaid health plans:

- Urged the state to consider cost-sharing to help control costs, but have also expressed concern about the selection pressure that some cost-sharing mechanisms, particularly premium increases, may cause. Administering cost-sharing will also create administrative expense.
- Have expressed interest in expansion since more dollars would come to plans as a result helping to stabilize administrative functions and risk.
- Have raised concerns regarding group and individual private market expansion since resources would not go to them and potentially would reduce resources over the long run and affect selection.

[*] See *www.ohppr.state.or.us* for this report.

- Are concerned that cost-sharing would affect already complex reimbursement relationships.

Private insurers:

- Have expressed concern regarding crowdout due to public expansion.
- Are concerned about the effects of expansion on the individual market especially as it relates to potential selection issues and an increase in assessment for the Oregon Medical Insurance Pool—the high-risk pool.
- Have concerns about the future of the current Medicaid carriers, both as potential competitors in the private market and as a source of cost shift if the Medicaid market is further destabilized.

The last concern is one also shared by physicians and hospitals, concerned that resources for expansion may mean inadequate resources for reimbursement to providers. Oregon providers, particularly physicians, feel strongly that current resources are insufficient to insure long term stability. Data is available to support their concerns. All the health plans have expressed concern about the ability of the state to control costs within Medicaid, particularly prescription drug costs. Changes in Medicare fee for service and Medicare HMO reimbursement have very significant affects on Oregon providers. Oregon has low Medicare reimbursement levels compared to other states. Medicare reimbursement encourages inefficient delivery systems and penalizes efficient ones. States like Oregon have more difficulties competing for physician manpower as a result. Oregon hospitals are more vulnerable and less able to absorb Medicaid losses. Medicare also has deferred responding to financing prescription drug benefits. In a variety of ways this exposes states, their health plans and their providers to risk and financing obligations that the federal government should play more of a role in.

Oregon has responded to these concerns by organizing multiple efforts to involve health plans in the decision making process. It is likely, for example, that as a result of the above concerns there will be no expansion of the individual private market. Specific enrollment targets will be set in order to apportion resources between private and public coverage efforts. Multiple efforts are underway to stabilize costs especially around prescription drugs. Flexibility around benefits will be particularly important since this will reassure providers that other mechanisms are potentially available to stabilize Medicaid than limiting enrollment or limiting reimbursement.

Oregon has communicated its concerns regarding Medicare reimbursement to the federal government—to legislators, to the administration and in the courts.

CareOregon, a Medicaid-only managed care plan, is a supporter of the CHIP Too option, in large part because of that organization's mission. Safety net organizations range from interest to caution. CHIP Too should reduce cost shift and risk in a community. Some communities (such as Bend, Oregon) do not currently have many safety net resources and remain unsure of any future role.

What were your key lessons in how to work most effectively with the employer community in your State?

Oregon has enjoyed a good relationship with employers over the last 20 years of health reform.

Important lessons include:

- The needs and concerns of large, medium and small employers are separate and distinct.
- Agents and brokers play an important role in coverage expansion. They are an effective means of educating and informing the public. They reach a different audience in different ways than government does.
- Cost shifting to employers is an important issue. Oregon employers are very aware of the specific impact of the cost shift on premiums and the decrease in premiums that has resulted from Oregon's successes.
- The economy and workforce competition greatly impact health insurance coverage and benefits. Employment-based insurance is a more efficient means of keeping pace with population growth but responds to larger economic forces.
- Business and labor must be included in all discussion of universal coverage strategies. Each brings a unique vision and philosophy that helps focus the public/private discussion.

6.8 What are the key recommendations that your State can provide other States regarding the policy planning process?

Key recommendations include:

- Be as inclusive as possible—invite all stakeholders, all political viewpoints. Physicians and consumers are particularly important now and may offer opportunities for collaboration. The people who receive care, the people who provide care and the people who pay for care should all be involved. Even within seemingly homogeneous stakeholder groups there are differences that emerge. For example, consumer groups are developing significantly different and evolving attitudes regarding prescription drug issues.
- At least in the near term, states will continue to have significant numbers of uninsured. Both an access model, CHIP Too, and a coverage/insurance model, OHP2, are needed to effectively complement one another. The safety net, public sponsored providers and private providers can work together and complement each other.
- Be focused on a goal; be flexible on how to get there. Ownership of the goal and the strategy is important to success. Without sufficient flexibility and agreement on the goal there will be insufficient ownership.

- Accept incremental change. There is currently substantial agreement on goals around universal access/coverage. There is substantial diversity around strategies to achieve universal coverage. Agreement is more likely on pieces of the strategy, which will build trust. As trust grows, leaders will emerge.

- Acknowledge what is not working and change it. Often agreement on what is not working is easier than agreement on what is working. Changing what is not working creates opportunities to form coalitions and can provide resources for successful approaches.

- Acknowledge larger forces that may explain success or failure. Some of Oregon's successes were related to a great economy and to managed care. Some of Oregon's struggles are likewise related to forces having little to do with key OHP strategies. Acknowledging these factors improves your credibility.

- Identify champions and rely on them (if you are lucky, the Governor will be your champion). Work with your critics and respect them. The taxpayer needs to see both to feel comfortable that resources are being used wisely.

- Understand the information you have and use it repeatedly—it takes a while to sink in. Those who work in health policy understand the information much better than those who see it for the first, second or even third time. Information needs to be presented in multiple mediums and in varied contexts to be accepted as important by the diverse stakeholders who need to support the strategy. Information needs to be really well understood in order for others to use it. That dissemination of information is what really builds support.

- Information should include compelling individual stories. These stories help decision makers listen, to identify and place information within their own lives. Individual stories create responsibility and accountability. They put information and decisions in context. The uninsured do not tell their stories effectively. They are a diverse group--many are embarrassed by their inability to insure themselves, many are angry, many prefer to be uninsured and some don't care. Helping to share their stories is a worthwhile effort.

- Any success is temporary. Success almost always causes some to be concerned that your success was at their expense. Promoting your success may be interpreted as promoting their failure. Many specialists have alienated primary care physicians and many primary care physicians have done the same. The first question that should be asked in a successful strategy is how those not involved can be included in the next round.

- Urge stakeholders to be moderate in their expectations when successful. There is always a reaction to success that moderates the impact. A goal of "universal" is much more challenging than the usual business or government goal. There is always more to do, more coalitions to build, more understanding and support to encourage. You will likely need those who disagree with you to achieve a goal of universal access/coverage.

- Plan for transition, succession, and cycles. Transition is constant. Success may increase transition. The degree to which transition strategies are apparent stabilizes strategies.
- Learn from other states—study their mistakes and their successes. Anticipate differences and adjust your approach to compensate. Knowing what has been tried elsewhere improves your credibility. However most successful strategies don't work the first, second or sometimes third time. Don't be afraid to try again in a different way or at a different time. Windows of opportunity are important for success and may be the reason for a state's success or failure.

Section 7

Recommendations to the Federal Government

7.1 What coverage expansion options selected require federal waiver authority or other changes in federal law (e.g. SCHIP regulations, ERISA)?

Oregon is pursuing two coverage expansion options:

- ***OHP2*** proposes more flexibility around benefits, eligibility and benchmarks for benefit and contribution levels by employer-sponsored insurance; and
- ***CHIP Too*** proposes that children who are eligible but not yet enrolled be provided primary and preventive services through safety net clinics while coverage options are pursued.

Oregon intends to apply for waivers for OHP2 under the newly formulated Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative in order to secure federal financial participation for the Oregon Health Plan expansion outlined in House Bill 2519, passed by the 2001 Oregon Legislature. HIFA offers revised guidelines for section 1115 waivers and portends increased latitude for states interested in offering families their choice between publicly sponsored health coverage programs like Medicaid and CHIP, and subsidies for private insurance such as those available through Oregon's state-funded Family Health Insurance Assistance Program (FHIAP).

For OHP2, Oregon believes that it is more reasonable to seek HIFA 1115 waivers under Medicaid, rather than seeking HIFA 1115 waivers under CHIP. This will obviate the need for waivers under both Titles of the SSA, and will also mean that the expansion program design can be simpler and more feasible to implement and operate. Our approach will be as follows:

- Oregon's CHIP coverage program will operate as it currently does, offering the same health plans and benefits as the OHP Medicaid demonstration project begun with 1115 waivers awarded in 1993 (see below for explanation of CHIP Too).
- Oregon's Medicaid program will remain as it is under the current OHP Medicaid demonstration for the following populations, with health plans and benefits unchanged:
  - Aged
  - Blind
  - Disabled
  - Pregnant women
  - Children

- Parents in TANF (cash grant) families
- Adults receiving General Assistance

- Oregon will seek waivers allowing the creation of a second benefit plan that will apply to "new eligible adults." Savings from this new benefit plan will be applied to expansion for the categorically eligible, CHIP, and "new eligible" adults.

- FHIAP group coverage and individual insurance will be qualified for federal match through a benchmarking process whereby each employer-sponsored insurance (ESI) benefit package will have to meet or exceed a set of benchmarks testing both benefits and cost-sharing.

- FHIAP insurance will pass a cost-effectiveness test in order to assure the federal government that it will be spending no more in the aggregate on FHIAP coverage than it would have spent on the alternative public sponsored coverage (Medicaid or CHIP).

This approach will require waivers of Title XIX for both benefit and eligibility. Oregon is in the process of identifying precisely which parts of Title XIX will need to be waived to make the proposed OHP expansion feasible.[*] No exemption of ERISA will be required since Oregon's proposal does not include an employer mandate and will not attempt to impose requirements on self-insured employers.

These changes would enable states to offer workable, cost effective family coverage options. With these changes:

- Families will have the option to have the same coverage for the entire family while the state is able to leverage the employer contribution.

- Families concerned about public coverage will have the option to cover their children like their fellow employees do.

Benefit flexibility would allow states to expand coverage more efficiently with resources available. Such flexibility would encourage coordination of employer, individual, and community funding streams with state and federal funding streams.

Oregon has submitted the CHIP Too waiver to the federal government. The waiver requests CHIP funds for direct payment to safety nets providing primary care and preventive services to CHIP eligible children who are not yet enrolled. The waiver is being pursued under the public health portion of the CHIP program. Approaches like CHIP Too would recognize the limits of conventional options for children while providing needed primary care and preventive services. At the same time coverage options could be promoted and the risk of periods of uninsurance could be reduced. This approach responds to the turnover we know is occurring among CHIP and Medicaid children. Continuity in relationships and care will be increased. An alternative to emergency room care will be available for children whose parents have failed to maintain their enrollment or initiate enrollment in a timely fashion.

[*] See Appendix I for further discussion of the waiver.

7.2 What coverage expansion options not selected require changes in federal law? What specific federal actions would be required to implement those changes and why should the federal government make those changes?

Oregon rejected the following expansion options in the process of selecting the approach described in Section 7.1 of this report:

- An employer mandate
- A single payer system
- A Medicaid only expansion
- A CHIP waiver for Title XXI funding of ESI enrollment of children and parents
- An individual mandate
- Market reform
- Expanded coverage for low to moderate income Medicare enrollees
- Community single stream financing
- Multi-tiered approach

Each of these "paths not chosen" would require changes in federal law. An ***employer mandate*** would require an exemption under ERISA since the state would need the ability to hold self-insured as well as insured employers accountable to the standards of eligibility and coverage. In addition, an employer mandate would require the same set of waivers related to ESI that Oregon will seek for its chosen approach. This path was chosen by Oregon in the early 90s. Federal support for necessary changes in ERISA was not forthcoming

A ***single payer system*** would require the same sort of ERISA exemption as described above if the single payer imposed regulations on self-insured as well as insured employers. In addition, the pooling of funds from all sources that lies at the heart of the single payer model would require extensive changes in federal law and regulation, relating to all federally funded health care programs. This list includes: Medicaid, CHIP, Medicare, CHAMPUS, Indian Health Services, the federal employee health benefits program, federally qualified health centers, rural health centers, and migrant health clinics. Consensus has not been reached regarding key features, such as financing and utilization/cost approaches.[*] Some advocates are organizing a statewide ballot measure campaign to have voters weigh in on the single payer discussion.

A ***Medicaid-only expansion*** would require the least onerous changes to federal law and regulation. In fact, even without waivers, section 1931 of the SSA permits states to extend eligibility up the income scale beyond Oregon's policy objectives for all categorically linked groups. A waiver would be required to include in the expansion those adults not deemed worthy of Medicaid by Title XIX.

A ***CHIP waiver*** would not provide sufficient flexibility for families who have access to employer-sponsored insurance, since CHIP requires that persons eligible for Medicaid enroll in the Medicaid program. CHIP does not allow persons eligible for Medicaid to enroll in a CHIP program offering ESI.

[*] The HRSA Team examined several single payer proposals, including those put forth by AAFP and NGA.

An ***individual mandate*** would require substantial increase in state and federal support and significant political support among voters. While this option remains of interest to Oregon policymakers, the reality of state and federal funding over the near term favored incremental changes consistent with current approaches.

Multiple ***market reform ideas*** have been discussed, particularly around the small group market. For example, creation of a high-risk pool for small groups was considered. This would require that the federal government consider access to a high-risk pool as compliant with regulations requiring guaranteed issue. This would allow insurers to offer products to low risk small groups. Low risk groups are currently leaving the market due to high premiums related to age banding.

Some study was pursued of options around ***low- to moderate-income Medicare enrollees***. This would require either merging of Medicare and Medicaid funding streams (dual eligible) or expansion of coverage to Medicare enrollees who are underinsured (pre-eligible), a concept that the HRSA team struggled to define. This option did not fit with the strategies chosen, which focus on those without insurance coverage.

One Oregon community approached us regarding ***single stream financing.*** This organization is already that community's sole Medicaid provider and felt that combined Medicaid and Medicare funding would be advantageous. They proposed to organize a Medicare HMO option and a fee-for-service option, one of which would be chosen by every Medicare resident in their delivery area. This approach would require a significant Medicare demonstration.

One Oregon foundation is developing a universal access proposal that involves ***multiple segments of care***, including an organized safety net available to all, a community rated managed care segment, and a self-directed market oriented segment. Significant changes in financing would be needed to assure that reasonable care is available to all.

7.3 What additional support should the federal government provide in terms of surveys or other efforts to identify the uninsured in states?

Oregon's recommendations to the federal government center around four types of support collaboration, providing guidance, funding survey efforts, and acting as a clearinghouse for information. The federal government should:

- Convene states to collaborate on information system issues. Consideration should be given to partnering with states to fund such collaborative efforts and share the results of such efforts with other states for minimal investment.
- Organize potential key pieces of information and make them available to states. For example, there is currently no single source for submitted and approved waiver documents. States could build on the experience of other states in determining strategies and waiver arguments.
- Fund surveys focused on specific target populations of uninsured, such as low-income, employed individuals eligible for employer-sponsored sponsored insurance. Issues such as access, choice, equity, affordability, and benefit priorities could be surveyed.

- Provide guidance to states regarding new survey strategies that generate acceptable response rates and accurately represent target populations.
- Collaboration, both among states and between the federal government and states, should be encouraged on survey methodologies of various types—ESI, disparities surveys, etc.
- Increase the distribution of MEPS—IC data. The MEPS cost-sharing and premium information provided by the Agency for Healthcare Research and Quality was very useful to Oregon. The U.S. Census Bureau could re-package this information in an easier to use format and then widely circulate it.
- Reconcile the Current Population Survey with state-specific surveys, such as the Oregon Population Survey.*
- Continue to help states define what is meant by *underinsurance*.
- Assist with tools to distinguish between those who choose to go without insurance and those who want it, but cannot obtain it.
- Consider funding and coordination of manpower/capacity/access studies that would provide state, regional and local data. These studies should examine the effects of different delivery system options on health care workforce issues.

7.4 What additional research should be conducted (either by the federal government, foundations, or other organizations) to assist in identifying the uninsured or developing coverage expansion programs?

- Oregon sees the need for additional longitudinal tracking studies to better understand the dynamics of people enrolling and disenrolling from public programs, such as a study that would link insurance status with health status. Questions still unanswered include:
  - From a health care perspective, what happens to people who leave Medicaid?
  - How are their long-term health needs met?
  - How many purchase insurance? What kind? What is the effect?
  - How important is the delivery system (HMOs versus safety net versus other forms of delivery)?

  One previously cited study, *Continuity and Turbulence in an Expanded Medicaid Managed Care Program, The Oregon Health Plan Experience*, provided insight about churning within the Medicaid population, but its scope did not include the ongoing health status or decision-making strategies of people who come and go from coverage.
- Funding of studies of state efforts should be continued and encouraged. For example, states have pursued subsidies for employer-sponsored sponsored insurance, the use of

* Discussed in detail in Section 1 of this report.

high risk pools that provide coverage to individuals willing to purchase insurance but unable to, and other state-based strategies. These state approaches should be studied in a cooperative fashion, identifying best practices and sharing that information broadly among states. The federal government should encourage these efforts.

- The federal government should consider large demonstrations of innovative approaches, for example, an individual mandate. This would require a substantial, long-term investment for program design, implementation, and support for subsidies and tax credits needed for a program to be fully carried out and evaluated.
- Consideration should be given to funding of community-based demonstrations. Some communities in Oregon are more capable of pursuing universal coverage strategies than others. Demonstrations of single funding stream concepts and access/coverage options should be considered on a community basis.
- The federal government should consider research in areas where complementary access and coverage strategies are being tried. A single strategy is unlikely to lead to universal coverage. Complementary strategies may be more successful.
- While it is important to lower the uninsurance rate, there should be funding of studies to assess adequacy of coverage and issues of underinsurance. As states work to design coverage expansion programs, we also need to continually measure changes in access to health care services and it's corresponding effect on health status.
- The federal government should identify a single coordinating/contact office regarding state efforts to expand coverage.
- The federal government should study delivery system innovations that are emerging as managed care changes.
- Concerns are constantly expressed in Oregon that manpower/capacity/access is insufficient to care for additional covered populations. No adequate data is available to assess these concerns.
- The OHP2 approach will raise questions and concerns about cost-sharing in the Medicaid population. Studies should be done to determine the effects of cost-sharing on specific benefit packages and the specific and overall impact of cost-sharing. Strategies to target cost-sharing will emerge. These strategies should be evaluated.

Appendix I

Baseline Information

A. Oregon Population: 3,436,750 (2000, Center for Population Research and Census, Portland State University)

B. Number and Percentage of Uninsured (current and trend):

Uninsurance in Oregon 1990–2000 *(Table 1.1, Section 1)*

Year	Uninsured Rate	# Uninsured
1990	16.4%	467,740
1992	18.1%	539,956
1994	13.6%	424,796
1996	10.7%	348,597
1998	11.0%	367,904
2000	12.3%	423,149

Source: *Office of Health Plan Policy and Research*

2000 Uninsured Rates by Poverty Status

Income Level	Uninsured Rate	# Uninsured
At or below 100% of FPL	26.4%	115,006
101–200%	18.9%	169,125
201–300%	9.4%	64,074
+300%	5.3%	74,944
All income levels	12.3%	423,149

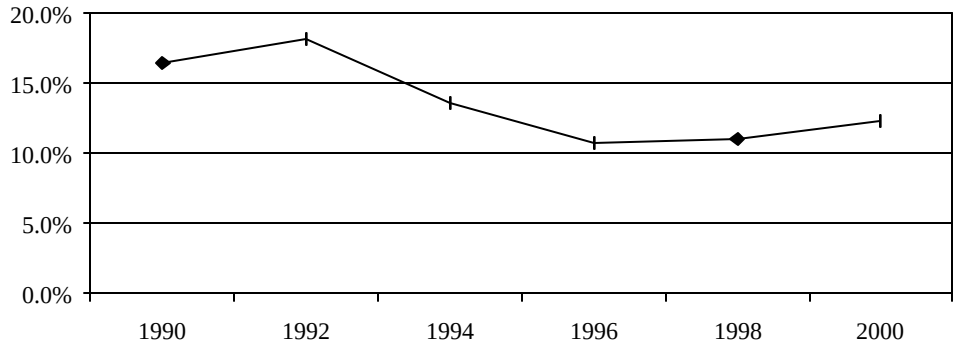
Source: *OPS 2000*

Number of Uninsured by Age and Income level

Age	0–100% FPL	101–200%	201–300%	+300%	Totals
0–18	24,013	35,925	9,482	12,034	81,454
19–64	84,073	129,966	52,959	61,702	328,700
65 +	6,920	3,234	1,633	1,208	12,995
Totals	115.006	169,125	64,074	74,944	423,149

Source: *OPS 2000*

Uninsured Rate: 1990–2000 *(Figure 1.A, Section 1)*



Source: *Office of Health Plan Policy and Research*

Uninsured Rates by Area of the State *(Table 1.21, Section 1)*

Region (see list below)	**Uninsured Rate**	**Estimated # Uninsured**	**% of All Uninsured**
Central Oregon	11.3%	17,432	4.1%
Eastern Oregon	15.0%	29,632	7.0%
Gorge	16.3%	8,267	1.9%
Metro	11.5%	161,717	38.2%
Mid-Valley	9.3%	41,643	9.8%
North Coast	10.5%	10,857	2.6%
South Valley	12.8%	69,630	16.5%
Southern/Central	14.3%	10,439	2.5%
Southwest	16.0%	73,531	17.4%
Totals	12.3%	423,149	100.0%

Source: *OPS 2000*

Region	**Counties**
Central Oregon	Crook, Deschutes, Jefferson
Eastern Oregon	Baker, Grant, Harney, Malheur, Morrow, Umatilla, Union, Wallowa
Gorge	Gilliam, Hood River, Sherman, Wasco, Wheeler
Metro	Clackamas, Multnomah, Washington
Mid-Valley	Marion, Polk, Yamhill
North Coast	Clatsop, Columbia, Tillamook
South Valley	Benton, Lane, Lincoln, Linn
South/Central	Klamath, Lake
Southern	Coos, Curry, Douglas, Jackson, Josephine

C. Average Age of Population:

36.3 (Median Age, 2000 Census; U.S. Census Bureau)

D. Percent of Population Living in Poverty (<100% of the FPL):

Percent of Population by Income Level

Income Level	Percent
At or below 100% of FPL	12.7%
101–200%	26.1%
201–300%	19.7%
+300%	41.5%
Totals	100.0%

Source: *OPS 2000*

E. Primary Industries:

Please see *www.oea.das.state.or.us/economic/appendixa.pdf* for a summary of employment by industry. Also see *http://bluebook.state.or.us/default.htm* for a more general description of Oregon's economic base. In addition, according to Oregon's Bureau of Labor Statistics *(http://stats.bls.gov/):*

Labor Force as of July, 2001: Non-farm Wage and Salary Employment

	# Persons (in 1000s)	% Total	12-Month % Change
Mining	1.8	0.1%	-5.3%
Construction	82.9	5.2%	-4.3%
Manufacturing	233.5	14.7%	-4.2%
Transportation and Public Utilities	79.9	5.0%	-0.4%
Trade (Wholesale and Retail)	391.2	24.6%	-1.4%
Finance, Insurance, Real Estate	95.1	6.0%	1.3%
Services	439.3	27.6%	-0.5%
Government	269.7	16.9%	0.1%
Totals	1593.4	100.0%	-1.3%

F. Number and Percent of Employers Offering Coverage:

Employers Offering Coverage

	# Employers Offering Coverage	% Employers
1–9	17,936	31.5%
10–24	8,364	71.9%
25–99	5,447	79.4%
100–999	5,154	91.5%
1000+	8,094	98.7%
Totals	44,996	50.4%

Source: *1998 MEPS*

G. Number and Percent of Self-insured Firms:

Self-insured Firms

Number of Employees	Total Firms	# Self-Insured Plans	% Firms that Offer Coverage[1]	% of All Firms[2]
Fewer than 50 EEs	72,290	3,505	12.0%	4.8%
50+ EEs	16,978	6,208	39.4%	36.6%
Totals	89,268	9,712	21.6%	10.9%

[1] *Number of firms that self insure at least one plan divided by total number of firms that offer any health coverage.*
[2] *Number of firms that self insure at least one plan divided by total number of firms.*

Source: *1998 MEPS*

H: Payer Mix:

Source of Health Insurance Coverage

Source	Percent
Employer	70.6%
Public	21.4%
Individual	8.0%
Totals	100.0%

Source: *OPS 2000*

I: Provider Competition: (from Section 3.6)

Oregon moved forward with initiatives in the late 1990s consistent with a market approach. The Family Health Insurance Assistance (FHIAP) program was created using state-only funds to subsidize low-income Oregonians for individual and employer-based insurance. Oregon eliminated some small group initiatives in the late 1990s because of the success of the small group market, notably the certified small group plans offered by the Insurance Pool Governing Board (IPGB).

Market reform, however, by definition creates winners and losers. Profit margins narrowed for both health plans and providers, competition increased, and given the profits of the mid-1990s, expectations increased. The late 1990s were marked by painful market adjustments. Large physician groups failed, particularly those pursuing physician practice management strategies. Many specialty physicians not sufficiently oriented to managed care left the market. Large hospital systems with dominant market shares used their clout in contracting to minimize, if not eliminate risk, while insisting on rate increases double the medical Consumer Price Index CPI. Surviving physicians organized into Independent Practice Associations IPAs to increase their negotiating clout.

Medicare HMO rate increases failed to keep up with provider expectations. Health plans were tossed about within the turbulence of market reform and patient protection. Eventually health plans and providers returned to cost shifting and selection strategies to survive. Commercial HMOs began to withdraw from Medicaid markets, reduce Medicare enrollments and pass along provider increases to their commercial customers. Hospitals returned to cost shifting to meet their increased profit expectations. Physicians began to overtly select better paying and less sick populations in order to survive and compete. Some Oregon markets experienced greater than 50% turnover within their primary care infrastructure, leading to uncertainty and instability. This tumult demonstrated to policymakers that market reform would also be incremental and would require timely intervention and guidance in order to be sustained.

By the late 1990s, it was clear that new strategies would be required for Oregon to weather these earlier efforts. Communities reacted by organizing community-oriented, provider-dominated delivery systems to care for Medicaid patients.

J. Insurance Market Reforms:

Following is a brief history of significant insurance market reforms in Oregon.

1989, Insurance Pool Governing Board (IPGB): This program, established by statue in 1987 was the first part of Oregon's health insurance reforms to become operational. The program's original intent was to increase the number of small employers who voluntarily provided health coverage for employees and their dependents.

1989, creation of a high risk insurance pool: The Oregon Medical Insurance Pool (OMIP) was designed to provide access to health insurance for people facing benefit limitations because of pre-existing conditions or for those refused insurance coverage by commercial carriers (and ineligible for Medicaid coverage).

Small business reform efforts included SB 1076 (which went into effect in 1993) and SB 152 (1994): SB 1076 was designed to level the playing field for small employers by mandating reforms in the underwriting, rating and marketing polices of health benefit insurers. SB 152 was designed to expand coverage to individuals and other groups. Major components of these two health insurance reforms include:

- *Eligibility:*

  SB 1076 was designed for small employers (3–25 eligible employees). SB 152 reforms were extended to 1) employers with from 2–25 employees; 2) any group with 2 or more members; 3) individuals leaving group coverage; 4) other individuals.

- *Guaranteed Issue:*

  As a condition of doing business in the state, insurance carriers under SB 1076 are required to make available to small employers an approved basic health plan. Benefits must be "substantially similar" to those provided to the Medicaid Demonstration portion of the Oregon Health Plan.

- *Guaranteed Renewability:*

  Under both pieces of legislation, carriers must continue to offer plan renewals to enrolled employers except where the number of eligible employees falls below a required participation level or in cases of non-payment, non-compliance, fraud or misrepresentation.

- *Underwriting Reforms:*

  Under SB 1076 no individual employee may be excluded from a small employer group plan because of existing or anticipated health status; the entire group is accepted or rejected in all health plans issued to small employers. Individual employees with pre-existing conditions cannot be excluded for more than 6 months and this restriction is waived for those employees with 6 months prior coverage in the small employer market. Pregnancy cannot be treated as a pre-existing condition.

- *Rating Rules:*

  Six geographic regions were established. By January 1 of each year, carriers are required to file geographic average rates (GAR), defined as the average rate for all health plans issued and marketed by a carrier within each geographic area. Premium rates cannot vary from the GAR by more than 33% unless they reflect additional benefits or differences in family size and composition. Premium variations within a plan must be based on family composition only; premium variations between plans must be based solely on differences in the benefits offered by each plan. In neither case can the health status of enrollees be part of the premium variations. Increases in rates are allowed once in a 12-month period as long as they do not exceed the GAR percentage change and are not more than a 15% increase.

- *Portability:*

  As of October 1, 1996 health insurance providers are required to provide individuals leaving their coverage after at least 6 months enrollment, a minimum of two standardized portability options—a low cost plan and a prevailing benefit plan. Portability plans are subject to the same requirements as other health benefit plans, i.e., guaranteed issue; ability to renew; no pre-existing condition exclusions; premium variations based only on geography, family composition, benefit design and/or age.

Individual market reforms include SB 152, which established a process for accepting or rejecting applicants for individual coverage based on a standardized health statement developed by the state. Accepted applicants cannot be excluded for pre-existing conditions over 6 months but pregnancy can be treated as a pre-existing condition. Premiums for individual coverage may vary only on the basis of geography, family composition, benefits and/or age and coverage is guaranteed renewable. Rejected applicants, who must be given written reasons for their rejection can purchase coverage through OMIP.

K. Eligibility for existing coverage programs (Medicaid/SCHIP/other):

The Oregon Health Plan includes four categories of people who may qualify for benefits:

- *Oregon Health Plan Basic (OHP-HPB):*

  Children and adults who qualify for medical assistance under the OHP-HPB income standard (below 100% of the FPL).

- *Oregon Health Plan for Children Under Age 6 (OHP-HP6):*

  Children under the age of six who qualify for medical assistance under the OHP-HP6 income standard (below 133% of the FPL).

- *Oregon Health Plan for Pregnant Females (OHP-HPP):*

  Pregnant females and infants under the age of one year who may qualify for medical assistance under the OHP-HPP income standard (below 170% of the FPL).

- *Oregon Health Plan for Children (OHP-HPC):*

  Children under the age of 19 who qualify for medical assistance authorized by the Children's Health Insurance Program (CHIP) provision of the Federal Balanced Budget Act of 1997 under the OHP-HPC income standard (170% of the FPL). Eligibility for this category is subject to the availability of state and federal funds.

For detailed eligibility standards for Medicaid and SCHIP, see:
www.sdsd.hr.state.or.us/resources/programs/index.htm.

L. Use of Federal waivers:

In June 2001, Oregon applied for a SCHIP demonstration project proposal under the authority of Section 1115 of the Social Security Act. Oregon wants to use a portion of its annual CHIP allocation to pay for primary and preventive care for children who are at or below the state's eligibility level for the CHIP program and whose parents cannot or will not complete the application process. This program would be called CHIP Too. Please see *www.ohppr.state.or.us* for a more complete description.

In July 2001, the Oregon State Legislature passed House Bill 2519 with the intent of increasing "access by Oregon's low-income, uninsured children and families to affordable health care coverage." Please see *http://pub.das.state.or.us/LEG_BILLS/PDFs/EHB2519.pdf* for the full text of HB 2519. Oregon will require Federal waivers before the state can put this plan into action.

Oregon has done a preliminary review of federal statutes and rules that may affect the ability to implement HB 2519. The following summary outlines some of the areas Oregon will have to consider in pursuing a waiver application. This list represents an initial effort and in no way reflects policy intent or strategy:

Waivers under the current OHP 1115 demonstration:

- Section 1902(a)(10)(B); 42 CFR 440.230-250—*Amount, Duration and Scope of Services:*

  To enable the state to redefine the Medicaid benefit package based on condition/treatment pairs and to permit coverage of benefits for the demonstration population which are not covered for the non-demonstration population.

  Oregon will continue to need this waiver under HB 2519. The State intends to establish three sets of benefits, OHP Plus, OHP Standard, and an employer-sponsored insurance (ESI) subsidy. Therefore, some Medicaid enrollees will receive benefits that are not covered for other enrollees. Oregon also intends to continue to use the prioritized list as the basis for the benefits package for OHP Plus.

- Section 1902(a)(1); 42 CFR 431.50—*Uniformity:*

  To enable the State to provide certain types of managed care plans only in certain geographical areas of the state.

  This waiver will continue to be necessary. Types of managed care plans available will continue to vary by geographic area. Also, there will be different sets of benefits for OHP Plus, OHP Standard, and the ESI subsidy. There may be additional differences (not related to the benefits package) in participation requirements between the two OHP plans and the ESI subsidy program (enrollment process and time frame, treatment authorization requirements, delivery system, etc.).

- Section 1902(a)(10)(C); 42 CFR 435.301, 435.811, 435.845, 435.850-52, and 440.220—*Medically Needy Eligibility:*

  > *To enable the state to replace its current Medically Needy program with different eligibility rules, including raising the income eligibility level to 100% of the Federal poverty level for demonstration eligibles, and to waive the requirement that a Medically Needy program be available to pregnant women and children if it is available to other populations. The state may continue to operate its current Medically [sic] program for foster care and the aged, blind, and disabled.*

  Oregon Medical Assistance Program (OMAP) officials have told the HRSA Team that the Medically Needy population is covered by Medicaid for certain, limited services (including prescription drugs, mental health and chemical dependency services, and transportation) but is *not* part of the OHP demonstration. OMAP says that Oregon needs to retain this waiver, because without it, Oregon either needs to institute a Medically Needy program for the TANF and PLM populations, or discontinue the Medically Needy program, as it is currently constituted.

  42 CFR 435.850-52 appear to have been repealed, so Oregon no longer needs these particular provisions to be waived. The original waiver application included a request for waiver of 42 CFR 435.831, which includes requirements for income offsets and other standards for calculating income for the Medically Needy population. This rule was not listed in the most recent list of waivers, quoted above. Oregon may wish to request reinstatement of a waiver of this rule.

- Section 1902(a)(17); 42 CFR 435.100 and 435.602-435.823—*Eligibility Standards:*

  > *To enable the state to waive the income disregards and resource limits, to base financial eligibility solely on gross income, to waive income deeming rules, and to base eligibility on household family unit (rather than individual income).*

  The reference to 42 CFR 435.100 dates to Oregon's initial 1991 waiver request. It probably should have included an "et seq." This rule, by itself, simply states "This subpart prescribes requirements for coverage of categorically needy individuals." Because Oregon reimposed an asset test in 1995 it is believe Oregon no longer needs a waiver of federal requirements for consideration of resources or assets for certain categorically eligible populations.

  However, Oregon needs to continue the waiver of section 1902(a)(17)(D) and 42 CFR 435.602 through 435.823, relating income disregards, income deeming rules, household units, and family responsibility in determining income eligibility for non-categorically eligible enrollees.

- Section 1902(a)(10)(A) and 1902(a)(34); 42 CFR 435.401 and 435.914—*Eligibility Procedures:*

  To enable the state to apply streamlined eligibility rules for demonstration eligibles who are not receiving or deemed to be receiving cash assistance. The 3-month retroactive coverage will not apply, and income eligibility will be based only on gross income.

  Oregon will continue to need a waiver of section 1902(a)(10)(A)—specifically the benefit requirements and maximum income eligibility thresholds cited in 1902(a)(10)(A). Rules associated with this statutory provision are found in 42 CFR 435.100 *et seq.* Oregon also needs to continue its waiver of section 1902(a)(34) and 42 CFR 435.914, the three month look-back requirement. In addition, if Oregon's Medicaid eligibility procedures continue to be more restrictive than those specified in the State's AFDC plan, Oregon will continue to need a waiver of 42 CFR 435.401.

- Section 1902(a)(23); 42 CFR 431.51—*Freedom of Choice:*

  To enable the state to restrict freedom-of-choice of provider.

  Oregon still needs this waiver in order to mandate enrollment in managed care.

- Section 1902(a)(30); 42 CFR 447.361—*Upper Payment Limit for Capitation Contracts:*

  To enable the state to set capitation rates that would exceed the costs to Medicaid on a fee-for-service basis.

  This waiver needs to be continued.

- Section 1902(a)(10) and 1902(a)(13)(C)—*Payment of Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs):*

  To enable the state to only provide FQHC and RHC services through managed care providers and not require payment to FQHCs and RHCs in accordance with Medicare cost reimbursement rules.

  Section 1902(a)(13)(C) of the SSA was recently repealed, and was replaced by new statutory standards regarding reimbursement of FQHCs and RHCs. However, CMS has not yet changed its rules regarding this issue (so needs further monitoring), but 42 CFR 447.371 still requires that rural health clinics be reimbursed at the Medicare rate.

  Congress adopted the new federal provisions regarding Medicaid reimbursement of FQHCs and RHCs last fall as part of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (H.R. 4577). These provisions have been included as section 1902(aa) of the SSA, and require that FQHCs and RHCs be reimbursed at cost. CMS has not yet proposed any rules regarding section 1902(aa), but the new law probably supersedes 42 CFR 447.371.

Therefore, Oregon may no longer need waivers of the above provisions. However, Oregon will clarify with CMS whether they intend to continue to enforce 42 CFR 447.371, and if so, Oregon may request a waiver of this rule. Oregon may also wish to seek a waiver of section 1902(aa) in regard to subsidization of employer-sponsored insurance.

- Section 1902(a)(43)(A)—*Early and Periodic Screening, Diagnosis, and Treatment (EPSDT):*

  To waive the requirement that states must pay for any service required to treat a condition identified during an EPSDT screening; some may not be offered, due to the redefined Medicaid benefit package.

  This waiver should be continued. Rules associated with the statutory mandate referenced above are found in 42 CFR 441, Subpart B.

- Section 1902(a)(13)(A)—*Disproportionate Share Hospital (DSH) Reimbursements:*

  To allow the state to not provide DSH payments when health plans are responsible for reimbursing hospitals.

  Oregon needs to continue this waiver.

In addition, the 1998 waiver extension letter from HCFA lists several standards regarding federal financial participation, based on section 1903 of the SSA, which are also waived:

- Expenditures to provide Medicaid coverage to individuals who would otherwise be excluded by virtue of enrollment in managed care delivery systems that do not meet all requirements of section 1903(m). Specifically, Oregon managed care plans will be required to meet all requirements of section 1903(m), except the following:

  1903(m)(1)(A) and (2)(A); 42 CFR 434.20 and 21, insofar as they restrict payment to a state that contracts for comprehensive services on a prepaid or other risk basis, unless such contracts are with entities that:

  a. *Meet Federal health maintenance organization (HMO) requirements or state HMO requirements;*

  b. *Allow Medicaid members to disenroll as set forth in section 1903(m)(2)(A)(vi). (The state will lock-in enrollees for periods of 6 months or more in FCHPs, PCOs, and PCCM organizations.)*

  As Oregon understand the issue, due to changes to federal law, Medicaid managed care organizations are no longer required to be either federally qualified HMOs or meet state HMO requirements. Section 1903(m)(1)(A) of the SSA and 42 CFR 434.20 now provide that contractors only have to meet the state Medicaid plan's definition of an HMO. Services must be as accessible to Medicaid enrollees as they are to any other enrollees in the plan, and provisions for assuring the solvency of the plan must exist. To the extent these conditions are being met by all of our contracting plans, Oregon may not need a waiver for this purpose.

At the time of Oregon's original OHP waiver, states were prohibited from locking Medicaid enrollees into an HMO, and Oregon received a waiver of this prohibition. Since then, the federal standards have been relaxed. 42 CFR 434.27(b)(2) and (e) now provide that enrollees can be locked into a managed care plan for up to 6 months, as long as they are given an opportunity to disenroll without cause during the first month of the enrollment period, or can show good cause for disenrollment during the remainder of the enrollment period. Oregon's Medicaid program initially contained such provisions, but the State has since received a waiver of the requirement for a grace period during the first month of enrollment. Therefore, Oregon continues to need a waiver of these requirements.

Section 1903(m) of the SSA used to require that contracting managed care organizations maintain an enrollment composition of no more than 75% Medicare and Medicaid enrollees. This requirement was eliminated from section 1903(m), but is still included in federal regulations at 42 CFR 434.26 and 434.27(d)(1)(i). Because this specific requirement was removed from statute, Oregon is unclear as to the statutory basis for this rule. The regulations cite 1903(m) (which no longer justifies this rule) and 1902(a)(4). Section 1902(a)(4) appears to be a catch-all provision, and is cited extensively throughout the federal Medicaid regulations as the basis for rulemaking. It requires that states operate their Medicaid programs in a "proper and efficient" manner. Oregon may wish to seek clarification from CMS regarding the validity and enforcement status of 42 CFR 434.26 and 434.27(d)(1)(i).

Another provision, for which Oregon used to have a waiver, is a requirement for HHS approval for any managed care contract of greater than $100,000. This provision has since been relaxed, but section 1903(m)(2)(A)(iii) of the SSA still requires that the Secretary must approve contracts in excess of $1 million in 1998 dollars. Oregon may wish to request a reinstatement of the waiver of this provision.

- Expenditures that might otherwise be disallowed under section 1903(f); 42 CFR 435.301 and 435.811, insofar as they restrict payment to a state for eligibles whose income is no more than 133% of the AFDC eligibility level.

  This waiver continues to be needed.

- Expenditures to provide Medicaid to individuals who have been guaranteed 6 months of Medicaid eligibility at the time they are enrolled in a capitated health plan, who were eligible for Medicaid when they were enrolled, and who ceased to be eligible during the 6-month period.

  This waiver continues to be needed.

- Expenditures for services provided to OHP-eligible individuals between the ages of 22 and 65 who are institutionalized for mental diseases. This exception is limited to short-term (less than 30 days) inpatient mental health care for persons in the Eastern Oregon Psychiatric Center.

  Oregon assumes this waiver should be continued.

- Expenditures which might otherwise be disallowed under section 1903(u), which establishes rules and procedures for disallowing Federal financial participation in erroneous Medicaid payments due to eligibility and recipient liability errors detected through a Medicaid eligibility quality control program.

  Oregon assumes this waiver should be continued.

- Chemical dependency treatment services which would have been disallowed under section 1905(a)(13) of the Act in the absence of a recommendation of a physician or other licensed practitioner.

  Oregon assumes this provision was waived in order to recognize Oregon's specific rules related to certification of chemical dependency providers, and to allow such a provider who is not "a physician or other licensed practitioner" to provide services without a referral. This waiver continues to be needed.

New waivers needed to implement HB 2519:

Cost sharing:

Oregon will need to obtain a waiver of certain provisions of section 1916 of the SSA, as referenced in section 1902(a)(14), and associated regulations. In addition, Oregon may need waivers for copayments for both OHP Plus and OHP Standard enrollees. The 2001-03 legislatively-approved budget calls for $2 and $3 drug copays and $5 outpatient copays for *all* Medicaid recipients, and there was apparently some statement of intent by legislators that providers should be compensated for uncollected copayments. Oregon will seek a *separate* waiver to implement any cost sharing adopted as part of the Medicaid prescription drug formulary.

Specific provisions that may need to be waived are listed below:

- *Section 1916(b)(1) and 42 CFR 447.52:*

  Statute provides that any premium must be related to income, and the associated rule establishes a schedule of maximum monthly premium charges based on gross family income and family size. Section 1916(a)(1) states that *no* premium may be imposed on most categorically eligible persons. However, because categorically eligible enrollees will be covered under OHP Plus and will not be subject to a premium, Oregon assumes the State will not need a waiver of this provision.

- *Section 1916(b)(2) and 42 CFR 447.53:*

  These provisions prohibit the imposition of any copay, deductible, or coinsurance for services to children, services related to pregnancy, services to certain health facility inpatients, emergency services, family planning services, and hospice services.

- *Section 1916(b)(3) and 42 CFR 447.54:*

  Statute provides that any cost-sharing must be "nominal in amount." 447.54 establishes schedules for maximum deductibles, coinsurance, and copays.

- *Section 1916(c):*

  This paragraph specifies that in the case of pregnant women and children under the age of 6 in families with income at least 150% of the FPL, monthly premiums cannot exceed 10% of the amount by which the family's income, less child care expenses, exceeds 150% of the FPL. Oregon found no regulations associated with this statutory provision.

- *Section 1916(d):*

  This paragraph states that for certain disabled and working enrollees with incomes from 150–200% of the FPL, any premiums must be set on a sliding scale from 0–100% of certain Medicare cost-sharing limits. Again, there do not appear to be any regulations associated with this provision.

- *Section 1902(a)(32) and section 1916(e); and 42 CFR 447.15, 447.57, and 447.58:*

  These provisions prohibit Medicaid providers from denying care to enrollees because of failure to pay a cost-sharing charge. In addition, 447.57 prohibits states from increasing provider payments to offset uncollected cost-sharing, and 447.58 prohibits states from adjusting capitation rates to managed care plans to offset uncollected cost-sharing.

- *Section 1916(g):*

  This statute specifies cost-sharing requirements for two categories of higher-income disabled persons who are eligible for Medicaid at the option of the state. There do not appear to be any regulations associated with this provision.

Subsidization of employer-sponsored insurance:

Oregon will need waivers to obtain federal financial participation for the expansion of employer-sponsored insurance (ESI) subsidies called for under HB 2519.

States with existing ESI subsidy programs, such as Wisconsin and Rhode Island, use section 1906 of the SSA as the basis for those programs. This statute governs the Health Insurance Premium Payment (HIPP) program. Under this program, states can obtain Medicaid matching funds to purchase private insurance for Medicaid enrollees when the enrollee has ESI available, and when subsidization of ESI is cost effective compared to direct Medicaid coverage. In such circumstances, states "shall provide for payment of all enrollee premiums for such enrollment and all deductibles, coinsurance, and other cost-sharing obligations for items and services otherwise covered under the State plan." In other words, states must provide wrap-around coverage under HIPP for any Medicaid services not covered by the private plan, and must pay all of the enrollee's cost-sharing under the plan. There do not appear to be regulations adopted related to HIPP. The statute calls upon HHS to "implement guidelines" for HIPP; if such guidelines exist, Oregon has not found them.

There are potential advantages to using the HIPP program as the vehicle for subsidizing ESI, most notably the small number of associated federal regulations. However OMAP and FHIAP staff have

indicated that there would substantial administrative and fiscal management problems with a broad-based expansion of the currently small HIPP program. A major problem involves the design and management of wraparound coverage. And basing Oregon's ESI subsidy program on the Medicaid benefits package, as would be required under HIPP, might run counter to the intent of HB 2519, which says that the benchmark for the subsidy program should take into account "employer-sponsored health benefit plans currently in the market." (HB 2519, section 5(3))

If Oregon does not base its ESI subsidy program on section 1906, then a number of waivers are needed. As stated in Oregon's comments on the CMS's proposed CHIP regulations last year:

> *Regulations assume that States can either comply directly or compel health plans to comply with a wide variety of specific reporting and other requirements. For health plans with which States have directly contracted… contractual provisions can be included to obtain whatever information and impose whatever requirements that are thought to be necessary (so long as enough plans will agree to contract on those terms). For employer-sponsored insurance coverage, no such contractual mechanism exists. The State is not the contracting entity. It simply provides premium assistance to enable families to enroll… in employer-sponsored insurance coverage that is available to them.*

Many of the waiver provisions already listed must also be waived for purposes of subsidizing ESI. For example, Oregon will need a waiver of the provisions of section 1916 of the SSA, regarding cost-sharing, in order to implement the ESI subsidy program.

In addition Oregon needs further study and discussion about how ESI subsidies might relate to categorically eligible persons. Such persons will presumably *not* be a part of the ESI subsidy program. However, CMS generally requires states to apply requirements for duration, scope and type of services to *all* persons eligible for Medicaid under each state's plan.

Following is a *very* preliminary list of standards that would need to be waived:

- *Section 1902(a)(3) and 42 CFR 431 Subpart E:*

  These require that enrollees be entitled to a hearing before the state Medicaid agency for any denial of services. State patient protection statutes provide hearing rights for people who are denied services by their private sector health plans, but these provisions are not identical to those in these federal Medicaid requirements.

- *Section 1902(a)(4) to the extent that it provides the basis for 42 CFR 455.18, 455.19, and 455 Subpart B. Section 1902(a)(4):*

  This is the "catch-all" provision discussed earlier. It requires that Medicaid programs be administered in a "proper and efficient" manner. 42 CFR 455.18 and 455.19 require that specific notices be printed on claims forms. 42 CFR 455 Subpart B requires disclosure of information on ownership, control, certain business transactions, and other information by providers.

- *Section 1902(a)(13)(B):*

  This requires reimbursement of hospice services at Medicare rates. Oregon was unable to find any rules that specifically discuss reimbursement of hospices, although 42 CFR 447.250(c) says that 447.253(c) and (d) are intended to implement section 1902(a)(13)(B) of the SSA. Because the State does not have the ability to define the rates at which private health plans reimburse providers, Oregon needs a waiver of this requirement.

- *Section 1902(16) and 42 CFR 431.52:*

  States are required to pay for services to enrollees that are provided when the enrollees are traveling out of state. Although most private health plans provide for out of area coverage, the conditions related to such coverage may not always comply with these provisions.

- *Section 1902(a)(30); and 42 CFR 447 Subpart F and Part 456:*

  These provisions create standards for payment and utilization review of Medicaid providers.

- *Section 1902(a)(32) and 42 CFR 447.15:*

  These require that providers must accept Medicaid rates as payment in full, and cannot deny services because of the enrollee's failure to meet cost-sharing requirements.

- *Section 1902(a)(37) and 42 CFR 447.45:*

  These require timely payment of claims. Oregon recently enacted a statute regarding timely claims payment by private sector health insurers, which requires quicker payment of claims than specified by these regulations (14 days *vs*. 30 days). But the state statute will not apply to self-insured plans, and specifics of the state law vary in a number of respects from the federal Medicaid requirements.

- *Section 1902(s):*

  This places several conditions on payments to disproportionate share hospitals for services to infants and children under age 6.

- *Section 1902(aa):*

  As discussed earlier, section 1902(aa) is a new statute that establishes Medicaid reimbursement standards for FQHCs and RHCs. Although Oregon might not need a waiver of these standards for other components of the state's Medicaid program, Oregon will need to waive these standards as they apply to subsidized ESI.

- *Section 1902(a)(25) and section 1906:*

  These statutes outline the requirements for recovery of third party liabilities, in situations in which a Medicaid enrollee is covered by a third party plan, and the

conditions under which states can provide for premium subsidies under the HIPP program discussed above. If Oregon is going to provide ESI subsidies outside of the HIPP framework, the State will probably need waivers for these provisions.

- *Section 1902(a)(27) and 42 CFR 431.107 and 431.108:*

  States are required to have agreements with all Medicaid providers concerning the data that the providers must collect and provide to the state.

- *Section 1902(a)(57) and section 1902(w); and 42 CFR 431.20*:

  These require record-keeping and notification of patients concerning their rights regarding advance directives.

- *Section 1903(m)(2) and section 1932 (as referenced in section 1903(m)(2)(A)(xi))*:

  These state that federal funds will not be made available to states for payment to health plans, unless the state contracts with the health plan. These statutes also set out a number of requirements concerning provisions to be included in such contracts, prohibit the state from requiring managed care enrollment for certain populations, and require that anyone mandated to enroll in managed care be given a choice of at least two plans. To the extent that section 1932 includes requirements for encounter data and other managed care reporting requirements, Oregon will need a waiver of such requirements for the ESI subsidy program.

- *Section 1903(m)(4)*:

  This requires that any Medicaid managed care organization that is not a federally qualified HMO must provide information to DHHS on certain transactions (assuming that a health plan receiving ESI subsidies *would* meet the definition of a "Medicaid managed care organization" under section 1903(m)(1) of the SSA, it would be subject to this reporting requirement).

- *Section 1911 and 42 CFR 431.110*:

  These require reimbursement of Indian Health Service facilities. Health plans receiving ESI subsidies may or may not have IHS facilities on their provider panels. The state will have no ability to specify whom they include or do not include as participating providers.

Other new waivers:

There are a few additional federal requirements for which Oregon might wish to seek waivers as part of the implementation of HB 2519. These include:

- *Section 1902(a)(4) to the extent that it provides the basis for 42 CFR 431.53:*

  This rule requires "that the Medicaid agency will ensure necessary transportation for recipients to and from providers." Oregon will need further research to determine if this only applies to categorically eligible enrollees.

- *Section 1902(b)(2) and 42 CFR 435.403*:

  These provisions require states to provide Medicaid coverage to any otherwise-eligible person who intends to reside in the state. Oregon may or may not wish to seek a waiver of this requirement, but it has been an issue in the legislature and in the public forums.

- *Section 1912(a)(1)(B) as referenced in section 1902(a)(45); and 42 CFR 435.610(2):*

  These provisions require that applicants "cooperate with the State in establishing paternity." OHP complies by including application questions to "establish paternity and pursue health care coverage from absent parents." Such questions might be difficult to include on the form used by the ESI subsidy component. Therefore, Oregon might need a waiver of these requirements.

- *Enrollment caps and entitlement:*

  Currently, FHIAP has an enrollment cap and a waiting list. Enrollment caps are allowed for CHIP, but not for Medicaid. If Oregon wants to continue an enrollment cap for the ESI subsidy program, and if a cap is placed on enrollment in OHP Standard Oregon will presumably need a waiver.

Appendix II

Links to Research Findings and Methodologies

Actuarial Modeling

Actuarial Impact of Cost-Sharing (diagram). Portland, OR: Oregon HRSA State Planning Grant; October 2001. *www.ohppr.org/hrsa/index_hrsa.htm*.

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Utilization Assumptions. Salem, OR: Oregon HRSA State Planning Grant; August 2001. *www.ohppr.org/hrsa/index_hrsa.htm*.

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Comments on the American Academy of Family Physicians (AAFP) draft proposal. Portland, OR: Oregon HRSA State Planning Grant; February 2001. *www.ohppr.org/hrsa/index_hrsa.htm*.

Cost Strategies for Oregon Health Plan medical services. Oregon HRSA State Planning Grant; July 2001. *www.ohppr.org/hrsa/index_hrsa.htm*.

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Plan Comparison Work. Salem, OR: Insurance Pool Governing Board and Health Insurance Reform Advisory Committee; September 2001. *www.ohppr.state.or.us* (see Waiver Application section).

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FHIAP Survey of Enrollees and Individuals on Reservation List: Summary Report. Portland, OR: Oregon Health Sciences University, Oregon Health Policy Institute; June 2001. *www.ohppr.org/hrsa/index_hrsa.htm*.

Options for Universal Health Coverage in Oregon: A Focus Group Study. Corvallis, OR: Oregon State University, Department of Anthropology; September 2001. *www.ohppr.org/hrsa/index_hrsa.htm*.

Statewide Household Survey on Health Care: Summary Report. Portland, OR: Portland State University, Survey Research Laboratory; August 2001. *www.ohppr.org/hrsa/index_hrsa.htm*.

Public Meetings

Public Meeting Stakeholder Participants and Organizations. In public meetings: Summary report. Salem, OR: Health Resources Commission/Oregon Health Policy; November 2001. *www.ohppr.state.or.us.*

Public Meetings: Summary Report. Salem, OR: Health Resources Commission/Oregon Health Policy and Research; October 2001. *www.ohppr.org/hrsa/index_hrsa.htm*.

Stakeholders Meetings: Summary Report. Salem, OR: Health Resources Commission/Oregon Health Policy and Research; October 2001. *www.ohppr.org/hrsa/index_hrsa.htm*.

Quality

Quality of Care and Patient Health Status: Goals, Objectives, and Actions. Portland, OR: Oregon HRSA State Planning Grant; August 2001. *www.ohppr.org/hrsa/index_hrsa.htm*.

Safety Net

Community-Based Delivery System (diagram). Portland, OR: Oregon HRSA State Planning Grant; May 2001. *www.ohppr.org/hrsa/index_hrsa.htm*.

Role of the Health Care Safety Net. Portland, OR: Oregon HRSA State Planning Grant; May 2001. *www.ohppr.org/hrsa/index_hrsa.htm*.

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